20 May 2006

C+D

Chemist+Druggist
Weekly news for pharmacy
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News: Scotland to follow England lead on Controlled Drug management plans

News: IT holds key to adverse drug reaction reporting says BMA

Cover Story: We profile the award winning Associated Chemists (Wicker) Ltd

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C+D

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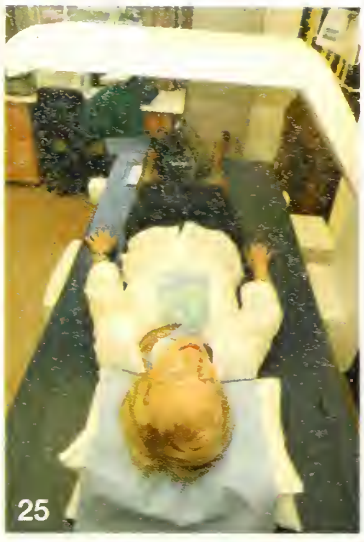

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Cover image [illegible] and managing [illegible] Chemists Wicker [illegible] Platinum Design [illegible], to C+D on page 40. Portrait by David Vickers/Photo Coordinates/Dollar Rae

Scotland mirrors English CD guidance

Policy New measures will come into force on June 5

Scotland is to put in place a programme of action to improve the management of controlled drugs, similar to that which came into effect in England from April 1.

Designed to improve the 'totality' of information held on controlled drug prescribing, the new measures are expected to come into force on June 5, and will:

- Introducing a standard private prescription form, PPCD (1) for the non-NHS prescription of schedule 2 and 3 controlled drugs.
- Amend both NHS and private prescription forms for schedule 2 and 3 controlled drugs to include a signature box, and additionally requiring people collecting prescriptions for schedule 2 controlled drugs to evidence their identity, at the pharmacist's discretion.
- Amend GP computer systems to include the suffix CD in the text of prescriptions for schedule 2 and 3 drugs. Prescriptions not including the CD suffix can still be accepted, however.
- Limit the validity of prescriptions for schedule 2, 3 and 4 controlled drugs to 28 days from the date signed by the prescriber.
- Limit the quantities prescribed for schedule 2, 3 and 4 controlled drugs to up to 30 days' clinical need.

NHS National Services Scotland will collate information on the private prescribing of schedule 2 and 3 controlled drugs, and will allocate identified codes to Scottish pharmacies that do not have an NHS dispensing contract. NHS pharmacies will be able to use their NHS code. **AC**

Chief pharmacist calls for 'strong leadership'

England Public confidence must be nurtured

England's chief pharmacist has called for strong collaborative leadership for the profession.

The last decade has seen a plethora of developments culminating in new roles such as independent prescribing and, if the public are to believe that pharmacists are the medicine experts, "strong, high profile professional leadership" is needed, said Keith Ridge. The DH's chief pharmacist, speaking at last weekend's Guild of Healthcare Pharmacists and UK Clinical Pharmacy Association conference, called on pharmacy organisations to work together around a common set of core principles to impact positively on patient care.

He said he wanted to see bodies speaking "firmly with gravity, constructively, intelligently and in a timely, informed and respected manner, with one voice on important professional issues that impact on patient care".

But collaborative leadership is also important at individual level, Dr Ridge said, highlighting how pharmacists are contributing as part of multi-disciplinary teams (see panel).

Keith Ridge: collaborative leadership

Pharmacists in multi-disciplinary teams

Eastern Hull PCT: a pharmacist works with a GP and other health professionals as part of a primary care team to tackle type 2 diabetes.

The pharmacist offers patients: MURs, monitoring of disease control, interpretation of blood results, and foot examination and referral. The pharmacist has a diploma in the diabetes management and supports a network of other pharmacists.

East Kent NHS and Social Care Partnership: a pharmacist is part of a multi-disciplinary 24-hour crisis in mental health team. All medication-related queries are directed to the pharmacist, who has a diploma and masters in clinical pharmacy.

The pharmacist also conducts home visits, provides treatment plans, monitors and ensures clinical compliance with treatment and acts as education resource on medicines usage.

Terry Hannawin: no firm date

NI contract from this year

Contract Next meeting scheduled for June

The new pharmacy contract in Northern Ireland will start to be phased in during the current financial year, the Department of Health, Social Services & Public Safety said.

The DHSSPSNI said illness at the Department has had no bearing on the progress of negotiations. The new director of primary care, Christine Jendoubi, will lead the department's team in the negotiations with the Pharmaceutical Contractors' Committee. The next meeting is scheduled for June.

Terry Hannawin, chief executive of PCCNI, agreed that the negotiations had been slow but said work had been continuing in the background. The results of the cost enquiry survey sent in January to 140 pharmacists, are being collated and the outcome will inform both the Department and PCC on the remuneration aspects of the new contract. The minor ailments scheme pilot has been extended to include allergy and it is hoped to increase the number of participants in the trial repeat dispensing service.

Nevertheless, Mr Hannaway could not give a firm date on when the contract would be implemented. "I don't see there'll be a D-Day," he said. "But I don't think progress has been that slow – we're 18 months behind Scotland, which originally said its contract would be implemented on April 1, but then delayed it to July 1. We intend to do our utmost to get it right rather than get it done." **JE**

Hampshire & IoW extends pharmacy oxygen service

Contract Original deadline was for three months, scheme will now run until July

Hampshire & Isle Of Wight PCTs are extending their interim community pharmacy oxygen service until the end of July.

The service, which is paid for as a local enhanced service, was commissioned in February to provide oxygen patients as a back-up to Allied Respiratory, the area's new regional supplier. Originally scheduled to last three months, the service will continue to involve pharmacists in providing services such as requests for urgent deliveries, and the collection and delivery of sets, cylinders or masks. The fee structure remains unchanged (C+D, Mar 4, p4).

According to LPC chief officer Mike Holden, the main reason for extending the service is to offer the PCTs a viable contingency service.

Although Allied is improving its service, he says there are still problems "with data, communication, and consistency of delivery and messages. In areas of high demand the PCT is still having to use community pharmacy services".

Mr Holden believes that by the end of July, the transition to Allied should be 95 per cent complete. He then expects the PCTs to scale down, but not stop, the community pharmacy based service. **AC**

'Daffodil Dementia' is one in a series of artworks on display at the Gardens of Remembrance exhibition at the National Botanical Gardens of Wales, organised by Cardiff University. The show explores the role of botanical gardens and illustrates plants with medicinal properties. This image is by Sci-Art fellow Dr Karen Ingham, whose portraits record botanical specimens used in pharmaceutical research into memory loss. Visit www.gardenofwales.org.uk

Job, not money, motivates women pharmacists with families

Practice Employers do not always appreciate committment, says study

Asha Fowells

Female pharmacists with young families choose to work because they enjoy it, not because they need the money, a small-scale study has shown.

Yet employers do not always appreciate the commitment of this workforce, said Wendy Gidman of Manchester University's Centre for Pharmacy Workforce Studies. She advised pharmacy owners to repay such employees by improving their working conditions, such as ensuring adequate staffing levels, to alleviate some of the pressures they are under.

Dr Gidman said there was an assumption that community pharmacy jobs were flexible and family friendly.

However, her research into the factors that influenced the working patterns of women pharmacists over 30 years with families – supported by the Pharmacy Practice Research Trust – had led her to meet a number who had moved to PCT jobs when the new pharmacy contract for England was introduced.

This particular cohort of study participants said their employers had reduced staffing levels yet expected new services to be implemented. Dr Gidman described this as an aggressive approach that was "driving women out of community pharmacy".

Subjects interviewed for the qualitative study said they wanted their work to fit in with family life and childcare arrangements, but said they were aware of their responsibility as pharmacist on duty so could not take emergency time off. A good support network outside their job appeared to be a large influence over the amount of work they did, said Dr Gidman.

Wendy Gidman: employers' aggressive approach is driving women out of community pharmacy

New SPGC chief executive

Scotland Harry McQuillan will be 'key' negotiator

Harry McQuillan: appointed this week

The Scottish Pharmaceutical General Council has appointed Harry McQuillan as chief executive.

Mr McQuillan was pharmacy director at NHS24 and played a major role in developing the patient group directives which underpin the CPUS community pharmacy prescribing initiative.

At the SPGC, Mr McQuillan, who takes up his new role on July 3, will lead pharmacy contract negotiations in Scotland into the next phase. **JE**

News in brief

IPF calls for support

Founder members of the Independent Pharmacy Federation are looking for pharmacists to support their new organisation.

IPF chiefs have sent out a flyer asking pharmacists to register their support. For more information see www.irxf.co.uk

Celesio booms

Lloydspharmacy owner Celesio registered a 21.4 per cent rise in like-for-like pre-tax profits during the first three months of 2006.

Control of entry review

Reforms to the control of entry regulations will be reviewed this year, the Department of Health confirmed in its Departmental Report 2006. It also outlined plans to consult on pharmacists' participation in [illegible]

BMA: IT holds key to ADR reporting

Practice NHS IT development offers opportunity to collect data through centrally held records, say doctors

Asha Fowells

IT offers a significant opportunity to improve adverse drug reaction (ADR) reporting, the British Medical Association has claimed.

Development of the NHS IT network means ADR data could be systematically collected through centrally held patient records, suggested the BMA in a report published last week. It added that Connecting for Health was discussing incorporating electronic Yellow Cards into the new system.

Launching the document, BMA science chairman Professor Sir Charles George stressed the importance of ADR reporting by all healthcare professionals and patients after products were launched.

"The reality is that very few drugs will have been given to more than 2,000 to 3,000 patients. So with unexpected effects, such as those that occur in one in 10,000 cases, there is no chance they will be recognised before marketing," he said.

Vivienne Nathanson, BMA professional activities director, said that Britain had one of the highest levels of pharmacovigilance, but warned: "We are only getting 10 per cent of ADRs reported so it is difficult to get in-depth knowledge of drug profiles." Black triangle and paediatric medicines required particular focus, she added.

Health professionals could be encouraged to report more adverse events through education. The methods and importance of pharmacovigilance should be covered at both undergraduate and continuing professional development levels, and should draw attention to major safety issues that have been identified through the Yellow Card scheme, said Professor Nathanson.

Commenting on the report, Anthony Cox, pharmacovigilance pharmacist at the West Midlands Centre for ADR Reporting, said pharmacists now accounted for 18 per cent of all Yellow Cards, despite only having full access to the scheme for seven years.

He added: "Pharmacists can also help by giving patients 'permission' to report an adverse reaction at the point of supply, perhaps suggesting they might return if they experience problems or by drawing attention to the patient reporting scheme at www.yellowcard.gov.uk.

"They are also well-placed to monitor OTC medication, and increasingly, herbal products; areas that may not be covered by other reporting groups."

The full report can be seen at www.tinyurl.com/gufpg

Beran Patel: link Yellow Cards to PMRs

Your views on ADRs

"Often people go to the doctor rather than here. But if I came across a new side effect, or one associated with a new drug, I would report it."
Will Lau, Co-op Pharmacy, Oldham.

"I've never found it necessary as I've never come across a bad enough reaction to report."
Chris Morris, Alliance Pharmacy, Mevagissey.

"I have done. But IT will help, especially when we are linked completely to NHSnet and can access full medical records. It would also help if there was an electronic version of the Yellow Card linked to the PMR – it would make the reporting process much easier."
Beran Patel, Brigstock Pharmacy, Croydon.

IIP recognition celebrated

Practice Pharmacy meets Investors in People standard

Staff at the Lynemouth Pharmacy in Northumberland were visited by councillor Milburn Douglas and his wife Ann, the mayor and mayoress of Castle Morpeth Borough Council, to celebrate achieving the Investors in People standard.

The event on May 11 followed six months of guidance from the local Business Link on staff development. Proprietor Mark Burdon said: "With the new contract it's essential that you get all the staff on board."

Pictured, from the left, are: Lilian Patterson, pharmacy technician; Mrs Douglas; Lesley Willis, pharmacy technician; Jan Smeaton, pharmacist; councillor Douglas; Mark Burdon, director; Ann Wheat, Business Link for Northumberland; Shirley Gray, pharmacy assistant; and Jackie Gowland, pharmacy assistant. **TH**

Opposition MP campaigns for oxygen compensation

Practice Challenge from shadow health minister over oxygen home delivery service expenses

A Conservative MP has urged the government to reimburse pharmacists left out of pocket by chaotic changes to the oxygen supply system.

Shadow health minister John Baron MP said this week he will continue to challenge the government until pharmacists are reimbursed appropriately for continuing home deliveries of oxygen since February 1 following the transfer to a centralised distribution model.

"Many pharmacists stepped in to get ministers out of a hole when the new arrangements for delivering oxygen collapsed within days of being introduced. I am now concerned that pharmacists should not be out of pocket for these actions," he said.

Mr Baron originally raised the question of whether the Department of Health planned to reimburse pharmacists for the cost of home delivery oxygen with former health secretary Jane Kennedy on May 2.

Despite a number of similar calls, the DH said the matter remained an issue between local PCTs and pharmacy contractors.

It added that plans for completing the transfer to centralised distribution later this year, which include continued supply by pharmacists, are being updated.

The DH expects new suppliers to contact "most" patients to confirm a start date for delivery by summer. It conceded that a small number would not switch until they come forward later in the year.

An early day motion urging the government to reconsider the transfer of home oxygen supplies has garnered the support of 64 MPs.

The supporters say the change has delayed delivery to 60,000 patients. **TH**

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2006-07 funding deal 'still some weeks away'

Contract Setback in financial deal as start of PSNC negotiations delayed

PSNC has admitted that the financial deal for the second year of the new pharmacy contract is still a good few weeks away.

Chief executive Sue Sharpe said that negotiations haven't even started yet. While the new 'formulaic' approach to the funding of the new contract has allowed a lot of the calculations to be done, PSNC feels it is unable to present a full funding claim until it has analysed the results of the second invoice inquiry, conducted in February.

This will allow it to present a comprehensive picture of the trends in retained purchase profits in community pharmacy. Mrs Sharpe said: "In this first, critical year, it is important to get it right."

She also believes that the shock resignation of Jane Kennedy is likely to delay matters even further, as new health minister Andy Burnham gets sufficiently up to speed on the contract and its funding.

Commenting, John Davies, retail services director at Mawdsleys, believes that the delay is unlikely to cause contractors problems, and that the reorganisation of the NHS remains a far greater concern.

"It is a great disappointment that contractors have made some fairly huge investments in their premises in order to provide a much broader range of services, but in most cases the funding and support from PCTs has just not been there. From that point of view the timing of the new contract couldn't have been worse, and I doubt much will change in the coming year as individuals at PCT and SHA level concentrate on resecuring their jobs." **AC**

The contract: how was it for you?

Alison Heath, secretary, Cambridgeshire LPC:
"PCTs have been very supportive of the public health campaigns and have been very relaxed about their contract monitoring visits, but made it clear from very early on that there would be no new money.

"PCTs have been distracted by the reorganisation, and I do believe things will get worse before they get better. Hopefully, practice based commissioning will bring some opportunities for pharmacy.

"As for the delay in the funding settlement, contractors simply now accept that they won't have a deal by April 1. They think it's the norm. More worrying for us are the new control of entry regulations – we've had a number of applications for 100-hour pharmacies."

Sue Sharpe: important to get it right

The contract: how was it for you?

Dr Karen Rosenbloom, executive officer, Bedfordshire LPC:
News on the financial outcome for 2006-07 would be welcome.

"I am uncomfortable at the prospect of more uncertainty, especially if there turns out to be a financial shortfall. We have already invested in premises without remuneration.

"The reorganisation of the NHS has diverted resources that could have been used to identify positive patient outcomes.

"I am also disappointed that there has not been a wider strategy to support the implementation of medicines use reviews; neither GPs nor patients seemed to understand what an MUR is for.

"On the positive side, the new contract has been an impetus to develop premises, which should be a green light for us doing other services in the future. I see year two as an opportunity for change and to better place pharmacy as part of the medicines management network."

For news on ETP and disaster recovery plans see page 10

More work for waste

Policy Clarification needed on definitions

Further work is needed before new healthcare waste management proposals can come into force, the Department of Health has admitted.

Responses to the consultation on safe management of healthcare waste have called for further clarification on the definitions of clinical waste, hazardous infectious waste, offensive waste, cytostatic and cytotoxic waste lists.

A healthcare waste management steering group is to consider how the disposal of medication from home care and self-medication will affect local authorities, local pharmacies or local doctors under take-back or needle exchange schemes. The steering group expects to publish definitive guidance by October.

See page 12 for news on the pharmacy sector's market share

Central dispensary helps put patients first

Multiples Patients received improved care while pharmacy teams focus on services

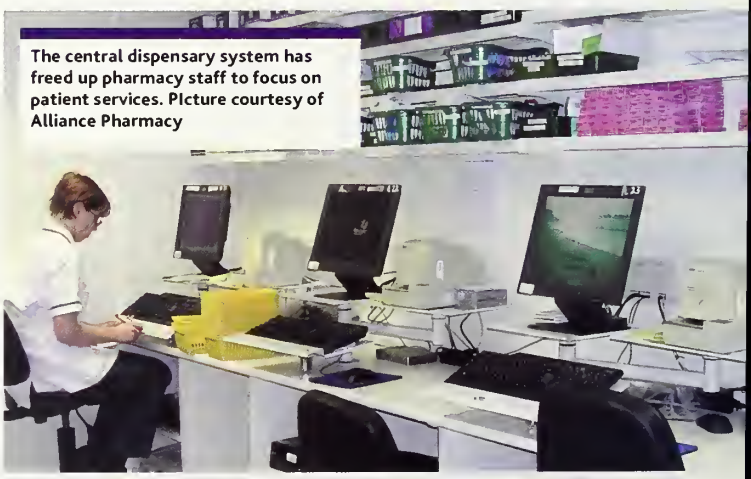
Max Gosney

A central dispensary system dealing with repeat prescriptions has helped boost healthcare services at four Alliance Pharmacy sites near Norwich.

The format, which is traditionally used to service care home orders, has helped free up pharmacy staff to focus on patient services, reported Chris Brown, Alliance Pharmacy's head of logistics.

"Our staff believe the system gives them a better quality of interface with patients. By assembling repeat prescriptions in a separate operation it allows our pharmacy teams to focus on medicines use reviews and other services," he said.

The participating pharmacies are based within 15 miles of the central dispensary site, which also distributes care home prescriptions, stated Alliance Pharmacy.



The central dispensary system has freed up pharmacy staff to focus on patient services. Picture courtesy of Alliance Pharmacy

The operation is housed at an Alliance Pharmacy in Hall Road, Norwich, which retains its own front-of-shop prescription dispensing service. The retailer could expand the central dispensing format in the future, revealed Jonathan Buisson, Alliance Pharmacy's NHS strategy manager.

"We've deliberately started with a small number of sites and when the system is running as planned we can look to expand. The central dispensary appears to work best in locations where there are a number of branches sharing resources like a delivery driver," he said.

Alliance Pharmacy plans to double the number of central dispensaries it operates to 16 by the end of 2007, Mr Buisson told C+D.

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Don't let smartcard snag stall ETP, says IT chief

IT Contractors urged to take the lead in introducing the technology

Max Gosney

Slow access to smartcards should not stop pharmacists pushing on with preparations for ETP, an IT expert has commented.

Anthony Roberts, UniChem's IT director, urged contractors to take a positive lead in introducing the technology, at an ETP forum held by the wholesaler in Leicester.

He said: "Many pharmacists are not aware of what their primary care trusts (PCTs) are doing to deploy smartcards. We've had reports of PCTs holding only a single card. But, it's important for pharmacists to put in place what they can control."

Contractors appeared primed to push ahead with ETP, reported Mr Roberts. "There is now ETP funding available and it's beginning to register with the majority of pharmacists that they need to do this," he added.

However, IT suppliers predicted major problems with introducing ETP unless PCTs stepped up the roll-out of smartcards.

Steve Langley, Cegedim's national accounts manager, who attended the event, said: "How can we roll out ETP systems to pharmacies when they don't have the smartcards needed to operate the systems?"

Current smartcard deployment figures were unimpressive according to Simon Driver, Cegedim's managing director. "I've heard around 3,000 smartcards have been issued, which is low when you consider the number of pharmacies in the UK. "We've had PCTs claiming that they won't issue cards until December and even one that thought we issued the cards."

UniChem plans further ETP events in Bristol, Newcastle, Elstree, Hertfordshire, Ealing and Croydon.

• Over one million prescriptions have been issued electronically, Connecting for Health (CfH) says.

Tim Donohoe, the organisation's group programme director, commented: "This is a significant milestone in the deployment of the service. But there is much work still to be done."

Currently, only AAH and Lloydspharmacy have had systems accredited for phase one ETP roll-out. Five other system suppliers are involved in CfH testing.

Anthony Roberts: take a positive lead

Anthony Roberts: what pharmacists should be doing

• Ensure you are working with a system supplier who is in the process of attaining ETP compliance.
• Plan for connection to the NHS network (N3) at the right time. This should follow the issue of a smartcard.
• Complete user training, end user registration and then claim for the £200 monthly funding.

Decide who counsels

Practice Bid to reduce drug-related admissions

Pharmacists and GPs need to define who should counsel patients on their medicines in order to prevent drug-related hospital admissions.

Each can assume the other has advised, leaving the patient with little or no information on their medication, warned Rachel Howard of the Nottingham Primary Care Research Partnership.

Knowledge gaps also contribute towards admissions. Pharmacists and GPs may not be fully aware of the risks posed by certain drugs, and computer systems that highlight interactions and side effects may not be user-friendly, Ms Howard said. Also, pharmacists could improve the information they give patients if they had access to health records.

The Pharmacy Practice Research Trust funded the research. **AF**

Learning about patient care

Education Interactive training available online

Pharmacists can learn more about clinical governance and its role in the new pharmacy contract from next week with the launch of a free online training programme.

The seven interactive modules, which are available from May 22, have been developed by the RPSGB and the NHS Clinical Governance Support Team in tandem with other healthcare organisations.

More information can be found at www.casu.interwise.com/casu/portal/ITCG. **AF**

Study backs advice setting

Practice Patients feel at centre of consultation

Patients like receiving a clinical pharmacy service in a practice setting, a founder of Greenlight Pharmacy in London has said.

Using a community pharmacy model that focuses on healthcare and medicines, Tim O'Donoghue said patients felt they were at the centre of consultations. A study funded by the Pharmacy Practice Research Trust has verified this approach, saying that it improves concordance.

However, Mr O'Donoghue said he wasn't sure how to apply the study findings to other pharmacies. Both patients and pharmacists needed to change their perception of how community pharmacies should look and operate for the model to be generalised, he suggested. **AF**

Joint effort gives pharmacy its own disaster recovery plan

Practice Guidance contains self-assessment checks

Terrorism, arson and pandemic flu are all covered in guidelines that have been drafted to help pharmacists formulate a disaster recovery plan.

The RPSGB, PSNC and Community Pharmacy Wales have joined forces to prepare the 21-page advisory document 'Service Continuity Planning'. It provides generic guidance on maintaining patient and customer support in an emergency that can be tailored to individual pharmacies.

Barbara Parsons, head of pharmacy practice at PSNC, said the guide identifies "issues for consideration when planning, where possible, to prevent emergencies and to set out actions, roles and responsibilities so that the impact of any emergency on community pharmacy services and patient care is minimised".

The guidance contains self-assessment checklists to minimise existing risks and analyse the potential impact of a disaster on services. It also highlights the legal pitfalls of reinstating business in a temporary form.

Suggested contents for an emergency pack and a template for a continuity plan are also included.

Pharmacists are advised to prepare for "service outages" from common emergencies such as fire and flood as well as terrorist attacks or pandemic flu, that have the potential to create a surge in demand. **TH**

News in brief

Hewitt cuts PCTs by half

The government is to slash the number of primary care trusts in England from 303 to 152 in a reorganisation of local healthcare.

From October 1, more than 70 per cent of PCTs will share local authority boundaries to improve links between the NHS and social services and avoid duplication of effort. Health secretary Patricia Hewitt said greater purchasing power and reduced administration costs would free up £250 million.

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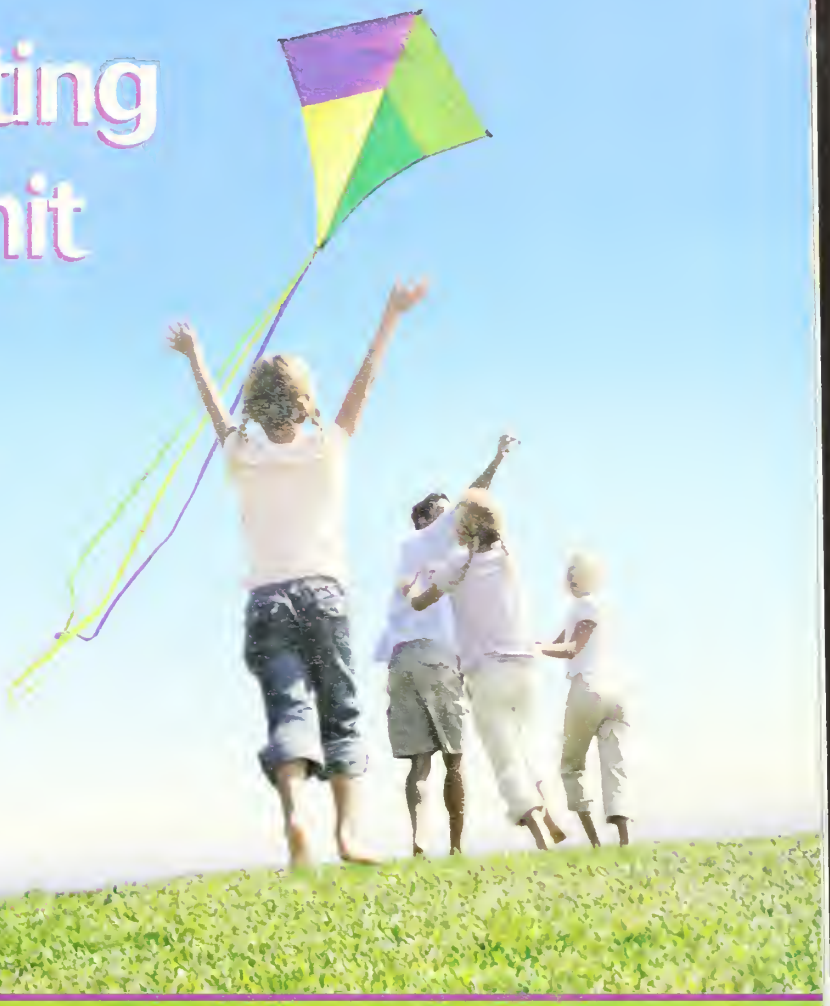

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Independent pharmacies maintain share in competitive market

Retailing Nucare conference delegates hear that the sector is holding up well against competition

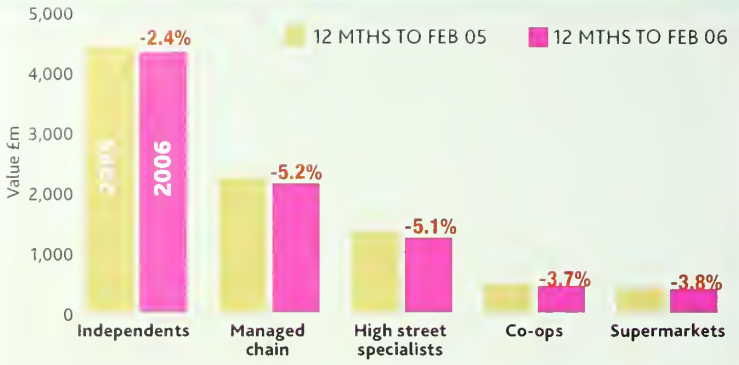
Gary Paragpuri

Independent pharmacies are maintaining their market share more successfully than multiple chains and supermarkets, according to UniChem's marketing director.

Independents' share of the market for ethicals, generics, PIs, surgical and P medicines fell only 2.4 per cent to just under £4,500 million for the year ending February 2006, Mark Stephenson highlighted at this month's Nucare conference.

But the managed chain sector, which includes Lloydspharmacy, Alliance Pharmacy and Rowlands, fell 5.2 per cent to just over £2,000m. The high street specialists (Boots and Superdrug), and supermarket sectors fell 5.1 per cent and 3.8 per cent respectively to around £1,300m and just under £500m.

Independents are the largest and best-performing sector



SOURCE IMS February 2006 includes; ethicals, generics, PI, surgical and P med. Note: high st specialists incl Boots & Superdrug; managed chain incl Lloyds, AP & Rowlands; independents incl single & groups

However, both independents and multiples are losing share to the supermarket sector when it comes to counter sales, Mr Stephenson highlighted.

In 2005, pharmacy had OTC sales of £1,233m compared to the grocery sector's £771m but, by 2010, pharmacy's share is predicted to fall to £1,150m, while grocery's share will rise to £924m.

Pharmacy businesses currently face a range of pressures and need to ensure that income from new services offsets income lost from purchase profits, Mr Stephenson warned.

In the next decade, 24-hour pharmacies will provide round-the-clock healthcare, Mr Stephenson predicted. Future patients will be willing to pay for services and become more knowledgeable and demanding, he added.

Numark shares ideas with NI members

Retailing Company plans bespoke training package and hears of contract progress concerns

Numark has held its first advisory committee meeting in Northern Ireland to help shape the organisation for members in the province.

At the meeting in Belfast, advisory group representatives Peter Wright and Garth Newberry from the Eastern health board, Sheelin McKeagney, Michael Hill and Seamus Strain from the Southern health board, Brendan Gormley and Patrick Kennedy of the Northern health board and David Hamilton of Sangers discussed contract negotiations, training, minor ailments and repeat dispensing services and monitored dosage systems with Mimi Lau, professional services controller at Numark.

Contract negotiations were thought to be progressing slowly between the Department and the Pharmaceutical Contractors Committee and the contract might not be implemented until 2007.

Ms Lau said Numark would develop a bespoke training package for pharmacy staff in Northern Ireland to cover areas such as retailing, HR management and business skills and investigate the possibility of working with the Wholesaler Retail Training Council, which some members had been using.

The company will be running a workshop on demystifying CPD in Belfast on July 11.

Other topics included customer loyalty cards, counter assistant of the year and out of stock own-label products.

"The meeting was a way for us to learn how pharmacy operates in Northern Ireland," said Ms Lau. "The funding is different from England and Wales. Many pharmacy services are running locally and we would like them to be national, but there are no clear guidelines yet."

Clockwise from the left: Garth Newberry, Peter Wright, Mimi Lau, Michael Hill, Patrick Kennedy and David Hamilton discuss issues such as Northern Ireland's contract negotiations and training at Numark's first Northern Ireland advisory committee meeting

The next meeting will be held on August 2. **JE**

£4 million drug and drink campaign in Northern Ireland

Campaign Five-year plan to tackle drug and alcohol misuse among young people

The government has kicked off a major project to tackle drugs and alcohol misuse among young people in Northern Ireland.

The five-year initiative launched by the Department of Health, Social Services and Public Safety is backed by first-year funding of £4 million.

It coincides with the publication of the government's 'New Strategic Direction for Alcohol and Drugs' and aims to target the cost of misuse to society in Northern Ireland.

A department spokesperson said the strategy would involve treatment and support for users as well as education and prevention programmes.

He added that the campaign would be "addressing local problems in local communities".

• Following the cabinet reshuffle the minister responsible for health in Northern Ireland will be Paul Goggins. He replaces Shaun Woodward, who has been appointed minister of creative industries and tourism. **TH**

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LAMISIL ONCE 1% CUTANEOUS SOLUTION. Presentation: Solution containing terbinafine hydrochloride 1.0% w/w. **Indications:** For the t... **administration:** The solution is applied once only, between the toes and to the soles and sides of both feet. Not recommended for patients unde... 18. Contra... or any of the excipients. **Precautions:** For external use only, avoid contact with the face and eyes. In the event of accidental contact with the eyes, ... event of an allergic reaction, remove the film with an organic solvent and warm soapy water. Not recommended for plantar (moccasin type) ... **Pregnancy and lactation:** Use in pregnancy only if clearly indicated. Not recommended for use in lactating mothers. **Side effects:** Redness, d... treatment if an allergic reaction occurs. **Legal category:** P. **Recommended Retail Price:** £5.70 (4g tube). **Product licence number:** PL ... Health, Wimblehurst Road, Horsham RH12 5AB. **Date of Preparation:** November 2005.

News in brief

Fast access to EHC

Pharmacies are more than twice as fast to supply emergency hormonal contraception as family planning clinics. A study of more than 200 women requesting the product found it took them an average of 16 hours to obtain it from a pharmacy, compared to 41 hours from a clinic.

NCSO endorsement

The Department of Health and the National Assembly for Wales have agreed to allow NCSO endorsements for May prescriptions for diamorphine 10mg and 30mg injection ampoules.

NPA pack approval

The National Pharmacy Association's medicines in care homes training pack has been accredited by the University of Abertay, Dundee. Designed to help pharmacists train care home staff, the pack now attracts points that can be used towards a masters degree.

MUR audit scheme aims to raise profile with GPs

Practice RPSGB's two-tier scheme will assist pharmacist and GP discussions

The RPSGB is developing a two-tier medicines use review audit scheme in an effort to improve awareness among GPs.

The Society is developing support for pharmacists completing the annual multi-disciplinary audit, which will form a tool to discuss MURs with GPs. This will supplement the MUR audit stipulated under the national contract that benchmarks a pharmacy's performance.

David Pruce, director of practice and quality improvement at the RPSGB, said: "GPs are still not aware of the benefits of MURs. Anything that brings together GPs and pharmacists is a good thing."

The MUR audits were discussed at a meeting of the RPSGB's practice committee on May 3. Recording interventions electronically, rather than on paper, was also on the agenda.

Talks are planned with software developers to include the documents on a database rather than in hard copy. The template for the system will be based on the guidance for interventions issued by the Society last month. The practice committee is also to be used as a sounding board for the development of the English national board.

David Pruce: GPs are still not aware of the benefits of MURs

The committee will develop a list of questions of items that need to be considered before the board comes into existence. On May 10, the RPSGB held an internal meeting to define the issues that will be put before the practice committee.

The practice committee also confirmed that the security logo being developed for online pharmacies will be available by the end of the summer. The RPSGB is planning a public launch of the stamp within the next few months. Mr Pruce said the logo would improve public protection.

"People should be able to know they are buying from a registered pharmacy and that the proper safety checks are in place,"he said. Mr Pruce conceded that the logo would not be entirely infallible to fraud. However, he said safety measures, such as a click through to the RPSGB site, would make it difficult to fake. **TH**

RPSGB policies shape pharmacy profession's ethical code

Regulation Law and ethics committee reviews progress on code of ethics in preparation for June consultation

Policymakers at the RPSGB have begun fine-tuning an eight-point set of guidelines to govern ethics within the pharmacy profession.

The Society's law and ethics committee discussed a working group report on the progress being made on the review of the code of ethics at a meeting on May 2.

The code will be based on seven or eight overarching principles. They are yet to be fixed but are likely to include elements such as maintaining professional knowledge and making care of patients a primary concern.

Consultation on the draft code is expected to begin at the end of June.

The committee also confirmed it will issue advice on the safe storage of home methadone supplies. This follows the death of a two-year-old in East Lothian in December, which prompted a review of Scotland's methadone programme. Committee chairman Doug Simpson said: "By drawing attention to a particular case and giving advice generally, hopefully it will be at the forefront of pharmacists' minds."

Pharmacists are also set to receive guidance on the reporting of sexual activity of pre-teens. The committee has finalised a document outlining situations where professional discretion can be employed rather than reporting all cases to the police.

The committee is currently also amending the process of prescribing, monitoring and recording controlled drugs in the wake of the Shipman Inquiry.

"Pharmacists will have to do more," said Mr Simpson. "Shipman got controlled drugs and used them in the way he did. These steps are being taken to see that doesn't happen again." **TH**

Diabetes programme a winner

Retailing Scheme provides service to community

UniChem's professional services division, Pharmacy Alliance, has won an award for its community pharmacy diabetes programme, set up with Hillingdon PCT.

Recognising that community pharmacists could play a vital role in the care of patients with diabetes and the attainment of diabetes targets, the programme was developed to increase patient accessibility to support and advice.

Ketan Amin, professional services manager at UniChem (far right), was presented with the award at the Primary Care Pharmacists' Association conference in London.

Pictured with Meera Sharma, professional services pharmacist, and Richard Balcon, NHS Services manager from UniChem's professional services team, Mr Amin said: "The PCPA award is a fantastic endorsement for UniChem, recognising our commitment to leading the way in the development and implementation of healthcare services in community pharmacy."

Allergy figures extrapolated from a TNS survey of 16-64 yr olds.

Temp home for fire-hit pharmacy

Retailing Portakabin restricting full range of services

A Midlands pharmacy has been forced to serve patients from a Portakabin for six months after being devastated by fire.

Alliance Pharmacy in Shawbirch, near Telford, is expecting to operate from the temporary location until the end of September, when its former location will have been rebuilt.

The pharmacy was gutted by a fire that started in the adjacent Spar supermarket last month. The Portakabin opened for business four days later after UniChem delivered the top 300 product lines. Further medicines were ordered for patients on the pharmacist's request.

The temporary location means the Alliance branch can no longer supervise methadone prescription or undertake MURs. The services will be restored in the refitted pharmacy, which will have a consultation room.

The fire was started when a cage of recycled material was set alight close to the rear of the building, which links the Spar and pharmacy with a dentist and doctors. It caused hundreds of thousands of pounds' worth of damage.

Catherine Whittaker, a dispenser at the site on Acorn Way, said the fire took hold in just 10 minutes. "Everyone was really worried because we thought the whole building was going to go but luckily it stopped when it got to our roof." **TH**

Entitlement cards prove free prescription eligibility in Wales

Policy Assistance for Welsh who have English GPs

A way has been found to help thousands of Welsh patients who feared they would have to continue paying for prescriptions while the rest of Wales get them free from April 1 next year.

A seminar held in the Welsh border town of Hay-on-Wye found a way of ensuring that some of its residents were spared paying the prescription levy in perpetuity, which would be otherwise be the case for Welsh patients registered with English GPs.

Initially, when free prescriptions were offered by First Minister Rhodri Morgan at the 2003 election, the problems were not realised.

When Cardiff health officials heard of English entrepreneurs planning to drive English prescriptions across to cheaper Welsh pharmacies, health minister Brian Gibbons reacted by printing Welsh prescription pads.

His officials have now come up with an answer for Welsh patients receiving prescriptions written on English pads. Dr Gibbons said that affected individuals will be issued with credit card-sized entitlement cards to be presented with their FP10 to prove they are Welsh.

However, some patients will complain that even this solution is not good enough as the card will be accepted only by a pharmacy contracted to a Welsh local health board, and not by any pharmacy in England. **CB**

News in brief

Strikes may hit pre-regs

The Royal Pharmaceutical Society has warned university lecturers that striking may impede students starting pre-registration training.

The Society has reminded all universities running the MPharm course that students must be assessed for their eligibility to enter the pre-registration year. A government committee on education was due to speak to employers and lecturers' unions after C+D went to press.

Amorolfine sales aid

Practice guidance on the pharmacy supply of amorolfine has been published by the RPSGB.

Available at www.rpsgb.org, the document provides information on diagnosing fungal nail infections, administration and action of amorolfine, cautions, side effects and interactions.

Piriton Allergy Tablets and Piriton Syrup Product Information. Presentations: Tablets containing 4 mg chlorphenamine maleate. Syrup containing 4 mg chlorphenamine maleate in 10 ml. **Uses:** Symptomatic relief of chickenpox itch and allergic conditions including hayfever. **Dosage and administration:** Tablets: *Adults:* 1 tablet every 4-6 hours. *Children aged 6-12:* ½ tablet every 4-6 hours. Syrup: *Adults* 10 ml every 4-6 hours. *Children aged 6-12:* 5 ml every 4-6 hours. *Children aged 2-6:* 2.5 ml every 4-6 hours. *Children aged 1-2:* 2.5 ml, twice daily. **Contraindications:** Hypersensitivity. Concurrent or recent treatment with MAOI. Pregnancy. Avoid effects of alcohol. May affect ability to drive and use machinery. Use with caution in prostate, respiratory, liver, cardiovascular and thyroid disease; epilepsy, glaucoma and other eye conditions. Syrup contains sucrose, caution in diabetes. Maintain good dental hygiene. **Side effects:** Sedation. Less commonly gastrointestinal disturbances, blurred vision, headaches, urinary retention, dry mouth, muscular incoordination, dizziness, blood disturbances, chest tightness, dizziness, blood dyscrasias, allergic reactions, tinnitis. Children and the elderly are more prone to the neurological anticholinergic effects and rarely may become excitable. **Pregnancy and lactation:** Consult doctor before use. **Legal category:** P. **Product licence numbers:** Tablets: PL 00036/0091, Syrup: PL 00036/0088. **Product licence holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantity and RSP:** Tablets 30s £3.15, Syrup 150 ml £3.99. **Date of last revision:** October 2004. Piriton is a registered trade mark of the GlaxoSmithKline group of companies

Comment from the editor

Wanted: one voice ... but whose?

Pharmacists who think their profession may not have been represented to best advantage may find the new chief pharmaceutical officer's comments interesting.

Dr Keith Ridge has called for stronger collaborative leadership of the profession. In particular, he would like to see pharmacy bodies speaking with one voice on important professional issues that impact on patient care.

As Dr Ridge will be overseeing the development of pharmacy potentially for a few years to come, his 'advice' should not be ignored. But isn't pharmacy already working together? Well, to a degree, yes.

Dr Ridge has pointed out that the long process that started with the Nuffield review in the 1980s has advanced to the point where pharmacists will soon become independent prescribers. This would not have been achieved if the profession had not pulled together.

Pharmacy has demonstrated its clinical abilities to the extent that this clinical input is now recognised, expected and relied upon by other health professions. The task now is to maintain and build on that position.

But the point about having a collective voice is not without its problems. Independent pharmacies have very different views, compared to large multiples, about what pharmacy services are needed; and the public does benefit by having a range of pharmacy service providers. Uniformity could stifle all that.

Perhaps pharmacy bodies may disagree with the chief pharmacist and do indeed work together to make sure each one is 'on message' in their individual communications with Whitehall.

But will the Department be looking for more? Might the Foster Review make the Society question its status? If regulation is taken away, could it beef up its representational role?

The grass may look greener, but doctors do seem to derive benefits via the BMA. Does pharmacy need its own equivalent? And would Whitehall like it?

> "The point about having a collective voice is not without its problems"

Your views

The future of the profession

NPA Comment: David Bealing says it's time to start planning to provide a pre-registration training place

From April 1, 2005, the government increased the grant for taking on a pre-registration student to £16,440 to encourage pharmacy owners to offer more placements. This welcome initiative should be a call to action for community pharmacists.

What's in it for community pharmacists? Firstly, the move helps recruit future pharmacists to community pharmacy rather than other sectors. It also means a steady supply of locums or second pharmacists once qualified.

Adding a pre-registration student to your team could bring new skills, different ways of working and an injection of updated clinical knowledge. All of these will benefit your customers as well as motivating other staff.

A pre-registration student offers you a great opportunity to make both short and long-term enhancements to your business. In the short-term they can be delegated a range of jobs within the pharmacy while learning about the profession themselves and help your business; for example by helping train other staff.

For the student, community pharmacy offers a huge variety of experiences. You can open the door to that; and in return you will be rewarded with enthusiasm, and a potentially highly valuable employee.

These students may only be with you for 52 weeks, but they could be part of your future workforce. Many community pharmacy owners feel it is an honour to have a pre-registration student, and to mould the final training of future members of the RPSGB.

The NPA is keen to support its members and our Pre-registration Service offers a scheme to match vacancies with students. The pharmacy has to be accredited by the Royal Pharmaceutical Society, so now is the time to arrange to have a pre-registration student next year, so contact the RPSGB to start the process.

David Bealing,
NPA commercial director.

A DPM with spare time on his hands...

... and how to keep him on the straight and narrow

Given the recent publicity in the media concerning those in ministerial posts in government, especially the straying from the straight and narrow confines of public life by our Deputy Prime Minister John Prescott, it occurred to me that in the ministerial reshuffle, Mr Blair might have considered offering Mr Prescott a post in community or hospital pharmacy.

In that way he could be assured that it would be totally impossible to start any task in working hours and see it through to completion without interruption, postponement or the need to undertake other jobs at the same time!!

On second thoughts though, given the DPM's reputation in his handling of both written and spoken English, any employment involving pharmaceutical and medical names and terminology might not be such a good idea after all!

Andrew RG Calder MRPharmS,
Platt Bridge, Wigan.

Email your views to chemdrug@cmpi.biz

Xrayser

Topical Reflections

More is less for pharmacy

So much for guaranteed purchase profits and payments for services. The government's latest plans for squeezing yet more money out of us (C+D, May 13, p4) indicate that every ruse will be employed to save yet more money at our expense and any payments for new services will simply be a partial recouping of money that used to be ours anyway.

This plan to cut reimbursement for dressing and chemical appliances is the latest bit of flesh trimmed from our bones but there are no signs that it will be the last. Using 100-hour pharmacies to save on out of hours payments is just another example of robbing pharmacy to pay everyone else. The list of these tricks is getting longer all the time, and goes back to before the removal of on-cost.

The irony is that while most sectors of the NHS, particularly doctors and nurses, are enjoying record funding, pharmacy is just keeping its head above water. While parts of the NHS are failing to make ends meet, the main reason seems to be that the government is paying GPs too much. But that really isn't pharmacists' fault.

The main reason that OOH costs are exceeding estimates is again that GPs are proving too expensive. Under their new contract, £6,000 was docked from a GP's pay for opting out of OOH care, yet it has cost £11,590 to replace each one, according to a story in The Guardian. GPs can earn up to £165 per hour for working out of hours, yet I see no plans to recover any of this overspend from GPs. Pharmacists are a much softer target.

What's happening here is that GPs are getting paid much more for doing less, while pharmacists are getting paid less for doing more. But then we're used to that.

Getting passionate about a good cause

Everyone is entitled to their opinion, but the group of animal rights activists who used their opinion to justify abhorrent acts have finally received jail sentences for their part in crimes that included grave robbing, blackmail and threatening to kill workers at a guinea pig farm. They have received undeserved publicity for their views as part of their campaign, but their sentences will hopefully serve as a warning to others that these acts are not justified under any circumstances.

While some people may believe that the activists' cause was right, very few will agree that their means were. And the only people who can stand up for this cause with a clear conscience are those that have never taken a medicinal drug, used a cosmetic or been sure that their money is never invested in any companies related to pharmaceuticals. I suspect that makes it a rather smaller group.

The people who recently threatened to publish names and addresses of GSK investors on their website are cowardly in the extreme, but these sort of tactics can be effective. As with most 'causes' it is the more passionate group that shouts the loudest and often gains the biggest swing in support of its views. This must not be allowed to happen in this case.

These activists are small in numbers and powerful only in their convictions. Healthcare professionals are powerful in numbers, education and influence. We must match them for conviction to see the right message gets across.

C+D

LPC Inbox

Are we losing the plot?

We have massively increased funding going into the NHS, but staff who deliver patient care are being made redundant. There are billions being poured into IT, but there appears to be little to show for it by way of tangible outcomes.

We have primary care organisations held as responsible and accountable to meet the needs of their locality yet we have a nationally imposed contract for oxygen that costs more, but delivers less.

PCOs also have to plan for the pharmaceutical service needs of their locality, but have to face control of entry regulations which allow any contractor committing to 100 hours per week to open where they like. Then when said contractor is required to deliver a directed service they go crying to the national press because their

We have primary care organisations held as responsible and accountable to meet the needs of their locality yet we have a nationally imposed contract for oxygen that costs more, but delivers less

commercial decision not to provide such a service blocks their application, yet their commercial activity often destroys existing community services. Additionally we have 100-hour contractors providing 'professional services' through a hatch to the public who are left standing in the rain in a car park the other occupants of which can hear their confidential consultation.

Finally we have a profession that is considering allowing some of its core services to be provided in the absence of its key healthcare professional.

Don't get me wrong, I am [illegible] change. When [illegible] and the Mr [illegible] are [illegible] [illegible]

Your views

Remote supervision is not in patients' interests

John Murphy, director of the Pharmacists' Defence Association, looks at the impact of the forthcoming Health Bill

When the Health Bill was introduced to Parliament last autumn, unsurprisingly the publicity centred on the banning of smoking in public places. In January, a PDA survey of over 400 pharmacists found that more than half did not realise the Act also proposed changes to the Medicines Act, neither did they appreciate the implications for pharmacy.

The PDA supports many of the proposals in the Bill and has always supported expanded roles for pharmacists.

The concept of the responsible pharmacist and his/her enhanced statutory authority, replacing the ambiguous notion of 'personal control', is an important development. We believe the closer the responsibility of the pharmacist to the patient, the safer the operation is likely to be. Under this new regime, it would increasingly be the responsible pharmacist and not the employer who would dictate workplace environment factors such as staffing levels.

These clearer lines of responsibility and accountability will invariably lead to a significantly improved career structure and salary scale for pharmacists. However, one proposal, which we cannot support, is that a pharmacy should be allowed to operate in the absence of a pharmacist through a system called 'remote supervision'. We believe that the arguments put forward to support this concept are flawed and cannot be in the interests of patient safety.

What are the PDA's concerns?

Community pharmacists and pharmacies have been synonymously linked, with members of the public enjoying instant access to a healthcare practitioner by simply attending any one of the UK's 12,000 pharmacies; the 'Ask your Pharmacist' campaign was built upon this principle.

In addition, the pharmacist is involved in ensuring the GP's prescribing intentions are not only safe, but that the patient receives the medication in the manner in which it was intended and understands how to take it. The remote supervision concept would impact detrimentally on these factors to a significant extent.

The plan is to allow a pharmacist to leave a pharmacy for periods of time to undertake a range of unspecified tasks whilst still assuming full legal and professional responsibility for anything that occurs in his/her absence.

The Department of Health has promulgated many reasons to support this proposal. It is our view that the risks would outweigh the benefits by a significant margin. So what are our concerns?

Reduced access

The DH contends that its proposals will improve patients' access to professional advice. If a pharmacist is not present, then reduced access is inevitable.

Patient Safety
The Department has also decreed that patient safety is paramount in its thinking. If indeed public safety is paramount, then how can a suggestion to allow the pharmacist to be absent be a realistic proposition? At best, absenting the pharmacist introduces new risks.

Support staff
Anyone with experience of working in a community pharmacy will know that if a pharmacist is absent, then members of the public will pressurise support staff to act outside the bounds of their competence.

One pharmacist for two or more pharmacies
Although the DH maintains that this will be the exception rather than the rule, the very fact that they will accept this as a possibility is the thin end of the wedge. We are concerned that the National Pharmacy Association has suggested that more than one pharmacy can be remotely supervised simultaneously by a single pharmacist using video links. It is perhaps unsurprising that the majority of pharmacists surveyed by the PDA felt that employers had most to gain from these proposals. Such a scenario will reduce access to

At best, absenting the pharmacist introduces new risks

the pharmacist, and erode the concept of pharmacist supervision, representing a significant risk to the public.

Helping to develop the wider role of the pharmacist
The DH intimates that allowing the pharmacist to be absent from the pharmacy will enable the pharmacist to develop new roles. This justification does not stand up to scrutiny.

The Health Bill does not stipulate what the pharmacist will be doing in their absence. DH officials have confirmed that regulations cannot be drawn to specify their activities whilst absent from the pharmacy. This means that pharmacists may simply be asked to remotely supervise from home by employers keen on cost-cutting.

The 'practicality' test
When remotely supervising, the pharmacist is to be immediately accessible by electronic technology in the event that they need to make an intervention. A pharmacist who is providing a domiciliary service may therefore face constant interruption. Whether electronic devices are used or not, this is the quickest way of ensuring that the wider clinical role for pharmacists fails the practicality test.

Control of entry
Since April 2005, control of entry has been relaxed for pharmacies open 100 hours per week. It should be of concern that those who want to open a pharmacy could do so without the pharmacist needing to be present for 100 hours, as it may be possible to supervise remotely during unsociable hours. This could seriously impact on the viability of the pharmacy network.

The PDA view
The Bill is described as 'enabling' legislation. This gives the health secretary the power to put in place regulations that will determine the extent to which remote supervision will be allowed.

The PDA has already mobilised a considerable campaign to attempt to bring to the attention of both Houses of Parliament the problems associated with the proposals for remote supervision. Our campaign has been focused on ensuring that the regulations are watertight, so as not to allow a pharmacy – unless under certain defined emergency conditions – to operate without the presence of a pharmacist.

We believe the best way to develop the wider clinical role would be to use the large resource of primary care, prescribing and locum pharmacists to support employees, without the need to simultaneously take responsibility for a community pharmacy in their absence. Such an approach would be better for patients and better for the profession.

Email your views to chemdrug@cmpi.biz or fax to 01732 367065

See pages 18 and 19 for more opinion ›

Pharmacy Champions

Pharmacists leading the way forward

Pharmacy Champions

What have you set up?
The Diabetes Plus service aims to ensure that patients can easily access resources for managing their diabetes.

It started from a conversation with a diabetes nurse who said she and her patients were consistently frustrated at receiving the wrong items for their prescriptions. I asked the nursing specialists to give us details of the medicines, equipment and devices that they were ordering; we would then pay particular attention to these prescriptions and make sure that patients received the correct supplies.

As working relationships developed, other needs became apparent. For example, there were continual problems with monitoring equipment and patients always seemed to run out of their medicines. We therefore trained everyone in troubleshooting the meters.

Included in the service are prescription and medicines management, delivery of medicines and equipment, information, advice and support, monitoring equipment training and sales.

DG Pharmacy also offers smoking cessation, healthy heart checks and screening services in addition to having an in-house podiatrist and links with opticians and dentists.

Were there difficulties?
Mainly with arranging training for staff – as with every pharmacy, trained staff leave and new staff have to be trained up. Staff also need time to become confident and comfortable about checking the monitoring equipment and offering advice rather than referring the patient to the pharmacist.

How have the locals reacted?
They like the fact that we've taken an interest in their condition and are on their doorstep should they need or want to ask anything. The diabetes nurse specialists really value what we do and ask us to keep an eye on their patients. The GPs are pretty oblivious to the service as a whole, but they know I have an interest in diabetes and will often phone about which test strips go with what meter and which pen needle size to choose.

Any advice for others?
First, see how you could contribute to fulfilling a need in patient care.

Name
Hooman Ghalamkari

Pharmacy
DG Pharmacy Health and Mobility, Dines Green, Worcester

What has he done?
Set up a Diabetes Plus service

Second, think of what you can do on a day-to-day basis – it need not be clinical, just a matter of putting emphasis on a patient group. Third, speak to patients and health professionals who are responsible for that particular disease area and see what other issues come up. Then try to formalise the things that you are already doing for patients.

Would you do anything differently?
I would have involved my staff more. This was really one of my initiatives and when I'm not in the pharmacy, they don't push it. Patients come in and demand the service rather than it being offered. I think staff need to take ownership of any new services that are set up.

Nominate your Pharmacy Champion: 01732 377688 or chemdrug@cmpi.biz

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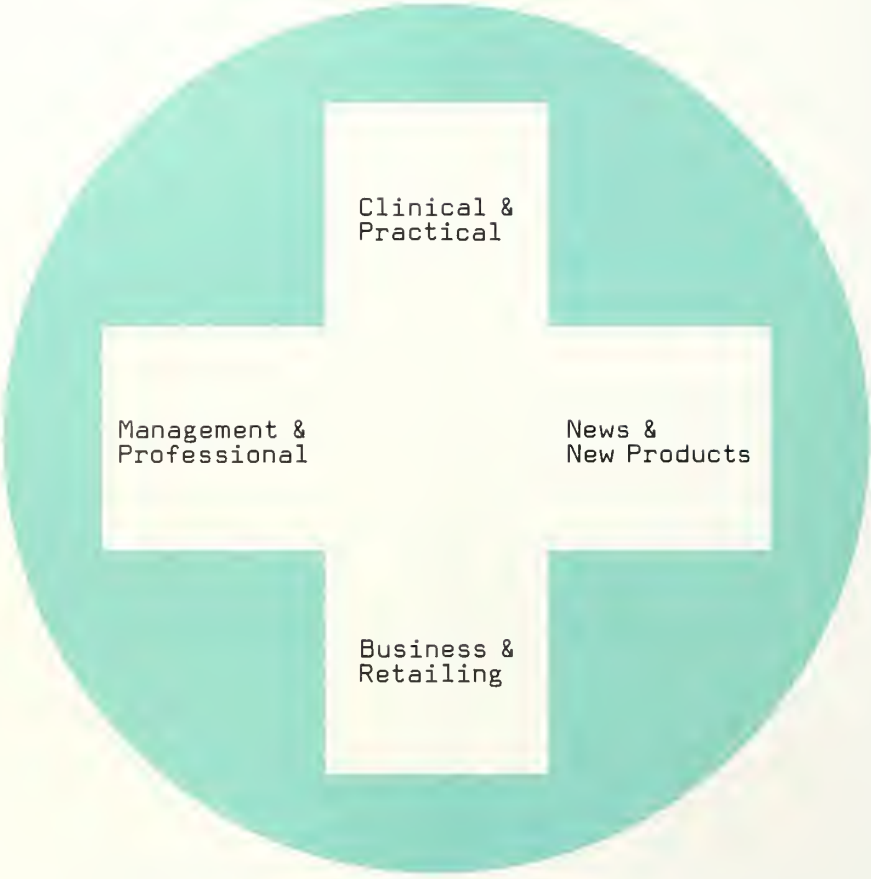

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Battling breaking bones

Preventing and treating the debilitating condition osteoporosis

Meera Sharma & Chris Martin

Osteoporosis is defined as a progressive systemic skeletal disease characterised by low bone mass and micro-architectural deterioration of bone tissue. This occurs when the holes between bone enlarge, leading to fragility and susceptibility to fractures.[1]

Pathophysiology

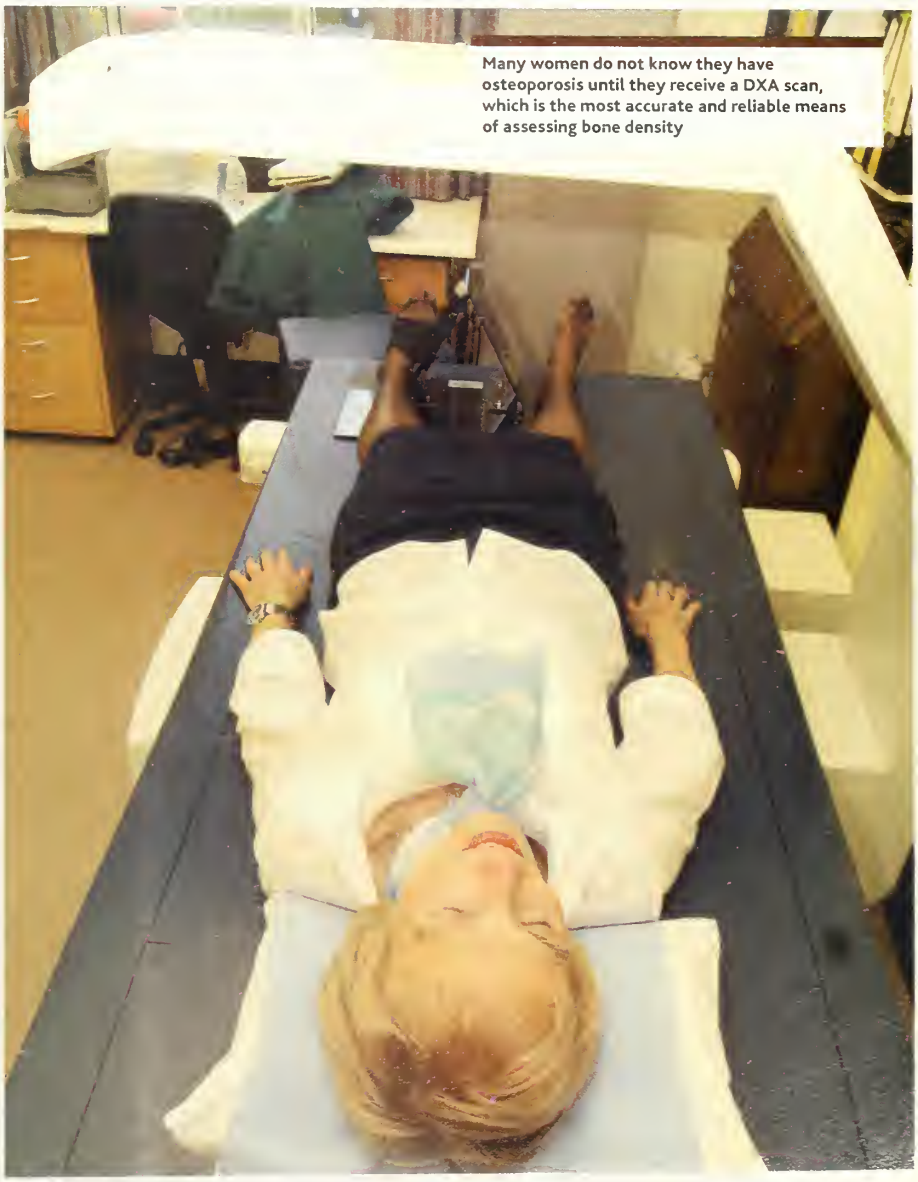
The skeletal bones are made of a thick outer shell and a strong inner mesh filled with collagen, calcium salts and other minerals. The inside looks like honeycomb, with blood vessels and bone marrow in the spaces between bone. Osteoporosis occurs when the holes between bone become bigger, making it fragile. The disease usually affects the whole skeleton but most commonly causes fractures of the wrist, spine and hip.

Monitoring

Osteoporosis is assessed in terms of bone strength and fracture risk. Measuring bone density helps to indicate bone strength. The most common method uses dual X-ray absorptiometry (DXA).

The result is normally stated as a T-score, which is the difference between the patient's bone density and the reference range of young healthy adults with average bone density. A T-score between 0 and -1 SD is considered to be within the normal range, between 1 and -2.5 SD is termed osteopenia, and below -2.5 SD is classed as osteoporosis (according to the National Osteoporosis Society).

A Z-score may also be calculated. This is the comparison between an individual's bone density and that of a reference range of people of the same age.



Many women do not know they have osteoporosis until they receive a DXA scan, which is the most accurate and reliable means of assessing bone density

Prevalence

Each year, 310,000 osteoporotic fractures occur in the UK at a cost of £1.7 billion and are a major cause of pain, disability and death.[2] One in three women and one in 12 men over the age of 50 years will sustain a spine, hip or wrist fracture.[2,3] Half of hip fracture patients lose the ability to live independently, and around 20 per cent of hip fracture patients die within a year as a result of the break.[4,5]

Risk factors

For women:

A lack of oestrogen, [illegible]ly

- Early menopa[illegible]
- Early hyst[illegible]

particular

The College of Pharmacy Practice

This course (module 1370) in association with multiple choice questions being published in C+D June 3, provides one hour's continuing education

CPD

This article can help in the following CPD competencies: G1a, G1c, G1e, C1c, C3b, C2e. See www.tinyurl.com/194zu

Figure 1: Secondary prevention of osteoporotic fractures

Age (years)	Bone Density Measurement	Recommendation
>75	No need for a DXA scan	Bisphosphonates
65-75	T-score of -2.5 confirmed on a DXA scan	Bisphosphonates
<65	• Very low bone mineral density (T-score of -3.2 or below), **or** • A low bone mineral density (T-score of -2.5 plus one or more risk factors, such as low body weight smoking, oral corticosteroids, untreated premature menopause, family history or prolonged immobility)	Bisphosphonates
	Raloxifene is recommended if the above criteria for treatment are met, but the patient is unable to take bisphophonates because of: • Side effects (including oesophageal ulceration, erosion or stricture, or lower GI symptoms), • Inability to take tablets correctly, **or** • Treatment failure, typified by a bone breaking easily despite treatment for over a year, or a DXA scan shows that bone density is lower than before treatment.	
	Teriparatide is recommended for post-menopausal women over the age of 65 years, who meet the above criteria for treatment but for whom bisphosphonates are unsuitable because of: • Side effects. • Inability to take tablets correctly, **or** • Treatment failure. They must also have: • Extremely low bone mineral density (T-score of -4 or below), **or** • Very low bone mineral density (T-score of -3 or below), **plus** more than two broken bones **plus** one or more risk factors (as above).	

ovaries (oophorectomy).
• Missing periods for six months or more (excluding pregnancy) as a result of over-exercising or over-dieting.

For men:
• Low levels of testosterone (hypogonadism).

For men and women:
• Long-term use of high dose corticosteroid tablets (for conditions such as arthritis and asthma).
• Close family history of osteoporosis (mother or father), particularly if the patient's mother suffered a hip fracture.
• Other medical conditions such as Cushing's Syndrome and liver and thyroid problems.
• Malabsorption problems (coeliac disease, Crohn's disease, gastric surgery).
• Long-term immobility.
• Heavy drinking.
• Lack of sufficient calcium from an early age.
• Smoking.

Treatments

The National Institute for Health and Clinical Excellence's guidance on the management and treatment of osteoporosis is sub-divided into two sections.[6]

Primary prevention
This focuses on preventing fractures in post-menopausal women who have osteoporosis but who have not broken a bone, and is likely to be published later this year. A consultation document suggested drugs should be prescribed only for women aged over 70 years, with bisphosphonates (eg, alendronic acid, risedronate sodium, disodium etidronate, ibandronic acid) the treatment of choice.

Secondary prevention
Secondary prevention focuses on preventing further fractures in post-menopausal women with osteoporosis who have already broken a bone. The recommendations are outlined in Figure 1.

Other treatments

Calcium and vitamin D
Supplements containing 1,200mg of calcium and 800iu of vitamin D can reduce the risk of broken hips in frail elderly people, particularly those living in nursing homes. It can also be prescribed alongside osteoporosis treatments such as bisphosphonates.

Hormone replacement therapy
HRT is no longer considered as a first-line treatment for osteoporosis, although it remains an effective treatment for women who have had an early menopause or who are having troublesome menopausal symptoms.

Strontium renalate
Currently being reviewed by Nice, with publication expected later this year.

Counselling points

Diet
Ensure diet is rich in calcium. Calcium-rich foods include milk and dairy products such as cheese and yoghurt. Non-dairy sources include green leafy vegetables, baked beans, bony fish and dried fruit. Other nutrients such as magnesium, potassium and antioxidants may help to maintain bone health. Excessive consumption of coffee, alcohol and salt may contribute to calcium loss.

Exercise
Regular weight bearing exercise should be undertaken for at least 20 minutes three times a week. Good bone building exercises include running, skipping, aerobics and brisk walking.

Smoking
Smoking has a toxic effect on the bone and can cause women to have an early menopause.

Alcohol
Drinking too much alcohol can damage bone turnover, so weekly intake should be limited to 21 units (men) or 14 units (women).

Vitamin D
Healthy exposure to sunlight will encourage synthesis of vitamin D, as will consumption of fortified foods (for example, margarines, fat spreads and breakfast cereals).

Alendronic acid
Tablets should be swallowed whole with plenty of water while sitting or standing, and taken on an empty stomach at least 30 minutes before breakfast or another oral medicine. Patients should be advised to stand or sit upright for at least 30 minutes after taking the tablet.

Risedronate sodium
Swallow tablets whole with a full glass of water, on an empty stomach, at least 30 minutes before first food or drink of the day. If taking at any other time of day, avoid food and drink for at least two hours before and after medication, particularly calcium-containing products such as milk. Also avoid iron and mineral supplements and antacids. Stand or sit upright for at least 30 minutes. Tablets should not be taken at bedtime or before rising.

Disodium etidronate
Avoid food for at least two hours before and after oral treatment, particularly calcium-containing products such as milk, and avoid iron and mineral supplements and antacids.

Ibandronic acid
Avoid food or drink (except water) for six hours before, and an hour after. Do not lie down for at least an hour after taking the tablet.

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HEALTH PERCEPTION

MUSCULAR TENSION AND JOINT DISCOMFORT

Minor Ailment Clinic

In this Minor Ailment Clinic:

Muscular tension and joint discomfort

- *CAUSES OF MUSCULAR TENSION AND JOINT DISCOMFORT*
- *ADVICE ON MAINTAINING JOINT FLEXIBILTY*
- *ROLE OF GLUCOSAMINE IN ALLEVIATING JOINT DISCOMFORT*


MUSCULAR TENSION
AND JOINT DISCOMFORT

MINOR AILMENT CLINIC

Muscular Tension and Joint Discomfort

Aches and pains are part of everyday life for many people, particularly as we get older. But joint discomfort and muscle tension can seriously affect some patients' quality of life. Pharmacists are well placed to advise and offer a range of solutions.

Osteoarthritis is the most common cause of joint pain, and is associated with factors such as ageing, obesity and physical injury, all of which contribute to degeneration of joint cartilage. Stiffness or misalignment of the joints and muscular tension can result in pain and discomfort and affect ease of movement.

More than 2 million people in the UK visited their GP in the past year with osteoarthritis and 2.6 million visited their GP with back pain. Arthritis and related conditions are the second most common cause of days off work, with 206 million working days lost in 1999-2000[1].

Skeletal muscle accounts for 40 per cent of body weight and a significant proportion of pain complaints. The commonest muscles affected are those in the neck, shoulder girdle, low back and hip girdle.

Most back pain is a result of muscle tension. Leading a sedentary life, taking too little exercise, postural imbalances, overstretching or excessive straining, poorly designed furniture and injury are by far the most common triggers, while skeletal abnormalities such as having one leg longer than the other, exaggerated curvation of the spine and over flexible joints can exacerbate tension in the back.

JOINT DISCOMFORT AND GLUCOSAMINE

Painful joints often have the following characteristics:

- Poor lubrication due to low hyaluronic acid levels.
- Painful movements due to an increased level of prostaglandins.
- Reduced cartilage depth on joint load-bearing surfaces.

Treatment with glucosamine can help in:

- Improving the viscosity of the synovial fluid.
- Relieving chronic pain and swelling within the joint.
- Increasing the articular cartilage depth on load bearing surfaces.
- Improving pain control.
- Aiding tissue healing in patients with musculoskeletal injuries.

CASE STUDIES

1. The squash injury

Mr Jones is a 50 year-old squash player who is otherwise healthy but has been visiting the pharmacy increasingly regularly for analgesics and muscle rubs for strains and his "dodgy knee". His GP has said that the knee pain is simply due to wear and tear.
Mr Jones does not like taking painkillers on a regular basis. His knee is painful for much of the time and limits his mobility. He asks if there are any other options.

2. The golf fan

Mrs Smith is a 45 year-old lady who has been experiencing increasing discomfort in her elbow and back after playing golf. She puts the discomfort down to a combination of muscle strain and an old injury. She is otherwise well, apart from a gastric ulcer which prevents her from taking non-steroidal anti-inflammatory pain killers. She wants a long-lasting treatment and also asks for any tips on prevention.

The right advice

Prevention is better than cure and both patients should be given a few simple tips to help avoid joint discomfort and muscular tension (see box). Poor posture and inadequate warm-up before exercise increase injury rates and aggravate old injuries.

Anti-inflammatory medication can help reduce symptoms, preferably given orally, but some patients prefer topical preparations. Mrs Smith should not take any NSAIDs because they will aggravate her ulcer, but should stick to paracetamol.

Heat rubs and liniments may also help. The massaging action increases blood flow to the area and soothes muscle tension. Heat rubs increase blood flow and exert a counter-irritant action. Heat patches can be applied to the affected area to exert their effect over several hours.

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- Start and end the day with some simple stretches.
- Always warm up before exercise with muscle stretching.
- Always have a cool down period with further stretches at the end of exercise.
- Vary the type of exercise undertaken to avoid repetitive strain on a particular joint.
- Ensure good posture when working at a desk or on a computer.
- Take a supplement of glucosamine and/or chondroitin, key components of synovial fluid and cartilage.

References
1. Arthritis Research Campaign
2. Ruane R, Griffiths P. Glucosamine therapy compared to ibuprofen for joint pain. British Journal of Community Nursing 2002 7(3):148-152.

Both patients could try glucosamine, either orally or topically, to help alleviate their joint problems. Glucosamine can help patients with mild to moderate joint complaints, as well as anyone with cartilage damage in one or two particular joints, such as people with sports injuries

A dose of 1,500mg of glucosamine daily helps reduce joint pain and increase mobility in stiff joints. Glucosamine 1.5mg daily has been found to be as effective as ibuprofen 1.2g daily at relieving osteoarthritic joint pain[2]. And it has been proven to give some degree of pain relief and improved mobility in subjects who experience regular, chronic knee pain due to cartilage damage and/or possible osteoarthritis

Glucosamine is an amino sugar produced naturally by the body from glucose and glutamine. It is specific to the connective tissue and found particularly in cartilage, tendons and ligaments. It has been described as the 'cement of the connective tissues' because one of its essential functions is to stimulate manufacture of cartilage components called glycosaminoglycans (CAGs) and proteoglycans (PGs). CAGs form the bulk of most cartilage tissue. Glucosamine also takes part in the synthesis of chondroitin sulphate and hyaluronic acid, both of which are depleted in arthritic conditions.

SOLUTIONS FROM HEALTH PERCEPTION

What better way to take pain away than applying a cooling soothing rub of glucosamine combined with horse chestnut extract and menthol? Flexible and cooling, the Gel Patch or Gel rub can be easily applied to localised areas of joint discomfort or muscular tension for a soothing sensation that lasts.

Health Perception's GlucOsamine Gel was developed in conjunction with the University of Brighton, where the formula underwent dermatological and clinical tests. The gel, which releases a cooling menthol vapour on application, is also infused with the soothing properties of horse chestnut extract which is known to act as an anti-inflammatory.

Health Perception recognised that not only does the skin provide a medium for prolonged delivery but also that the topical application of glucosamine is an excellent means of localising a problem area of discomfort. This product is ideal for all sportsmen and women and as we hit the summer sports scene, a great addition to the sports bags of tennis players, golfers and cricketers alike.

Taking this one stage further, Health Perception developed the GlucOsamine Gel Patch. Containing the GlucOsamine Gel, this flexible patch allows easy application to mobile areas such as the elbow, knee, wrist and ankle, as well as flat areas such as the neck, back and shoulders.

Dr Neil Barnes, an expert in hydrogel patch technology, says: "Research shows that patches are both effective and well accepted by the user who can feel the benefit of the patch for up to six hours."

Each patch is formulated to gently adhere to the skin and can be easily removed without leaving any sticky or greasy residue. Should extra support be required to hold the patch in place, each pack comes with special peel-off strips that can help to secure it during exercise.

Health Perception's GlucOsamine Gel and GelPatch retail at £6.99 for a 100ml tube and £7.99 for a box of five patches.

For further information please contact Health Perception on 01252 861 454 or visit *www.health-perception.co.uk*.

Information about adverse event reporting can be found at www.yellowcard.gov.uk.
Adverse events should be reported to Roche Products Limited. Please contact UK Drug Surveillance on: 01707 367554

PRESCRIBING INFORMATION. XENICAL (orlistat). **Indications:** XENICAL is indicated in conjunction with a mildly hypocaloric diet for the treatment of obese patients with a BMI ≥30 kg/m², or BMI ≥28 kg/m² with associated risk factors. Treatment should be discontinued after 12 weeks if patients have been unable to lose ≥5% of their body weight. **Dosage and administration:** One capsule immediately before, during or up to one hour after each of the three main meals. The patient should be on a nutritionally balanced, mildly hypocaloric diet (30% of calories from fat). Increase in faecal fat occurs 24 to 48 hours after dosing and upon discontinuation of therapy usually returns to pre-treatment levels within 48 to 72 hours. Patients with hepatic and/or renal impairment, children and elderly patients have not been studied. **Contra-indications:** Chronic malabsorption syndrome, cholestasis, breast-feeding, known hypersensitivity to any component of the product. **Side-effects:** Mainly gastrointestinal. During the first year of treatment, commonly observed events were oily spotting from the rectum, flatus with discharge, faecal urgency, fatty/oily stool, oily evacuation, increased defecation and faecal incontinence. The incidence of adverse events decreased with prolonged use of orlistat. Other adverse events were: abdominal pain/discomfort, flatulence, liquid stools, soft stools, rectal pain/discomfort, tooth disorder, gingival disorder, upper respiratory infection, lower respiratory infection, influenza, headache, menstrual irregularity, anxiety, fatigue, urinary tract infection, hypersensitivity reactions. Very rare cases of increases in liver transaminases and alkaline phosphatase and exceptional cases of hepatitis that may be serious. Very rare cases of bullous eruptions, diverticulitis and cholelithiasis. Treatment adverse events in type 2 diabetics included hypoglycaemia and abdominal distension. Reports of decreased prothrombin, increased INR and unbalanced anticoagulant treatment resulting in variations of haemostatic parameters have been reported in patients treated with anticoagulants in association with orlistat. **Precautions:** Anti-diabetic drug treatment may have to be closely monitored when taking orlistat. Co-administration of orlistat with cyclosporin is not recommended. Treatment may potentially impair the absorption of fat-soluble vitamins (A, D, E, and K). Patients should be advised to have a diet rich in fruit and vegetables and to adhere to the dietary recommendations as the possibility of experiencing gastrointestinal events may increase when orlistat is taken with a diet high in fat. If a multivitamin supplement is recommended, it should be taken at least two hours after orlistat or at bedtime. Caution should be exercised when prescribing to pregnant women. **Drug Interactions:** A decrease in cyclosporin levels has been observed in an interaction study and reported in several cases when orlistat was co-administered. This can lead to a decrease of immunosuppressive efficacy, therefore the combination is not recommended. If unavoidable, more frequent monitoring of cyclosporin blood levels should be performed following addition and upon discontinuation of orlistat until they have stabilised. In the absence of data, co-administration with acarbose should be avoided. Co-administration with warfarin or other anticoagulants should be monitored using INR values. Amiodarone plasma levels may be reduced when co-administered, reinforcement of clinical and ECG monitoring is warranted. No interactions with amitriptyline, atorvastatin, biguanides, digoxin, fluoxetine, losartan, phenytoin, oral contraceptives, pravastatin, nifedipine GITS, nifedipine slow release, ranitidine or alcohol were observed. **Legal Category:** POM. **Presentation and Basic NHS Cost:** Xenical 120mg (84 capsules) £34.51. **Marketing Authorisation Number:** EU/1/98/071/003. **Marketing Authorisation Holder:** Roche Products Limited, Welwyn Garden City, Hertfordshire AL7 1TW. Prescribing information is available on request. Xenical is a registered trademark of Roche Products Limited.

References
2. [illegible]
3. [illegible]

The community pharmacist's role

'The hidden burden of life in osteoporosis', a report published in December 2004 by the National Osteoporosis Society, showed that 77 per cent of patients taking a once-daily bisphosphonate stop taking their treatment within a year, as do almost two thirds of patients taking the drug once a week. The report says that adherent patients have a reduction in fracture rates of 16 to 23 per cent compared with non-adherent patients.

This non-adherence is thought to be due to lack of good quality information about the risks and benefits of treatment and non-treatment. Pharmacists are well placed to meet this need and support medicine taking in patients with osteoporosis. This can be addressed through medicines use reviews, as part of the advanced services tier of the pharmacy contract. A full medication review can also be offered as part of a locally commissioned enhanced service.

The benefits of such services have been clearly highlighted by the Bone Health Programme – Community Pharmacy Pilot (Wales) and the Havering PCT Osteoporosis Scanning Pilot.[7,8] As part of the Wales pilot, patients identified as being at risk of developing osteoporosis were promptly referred to their GPs, while their information analysis and calcium intake assessment was carried out in the community pharmacy.

The results showed that, at follow-up, the majority of patients self-managed their daily calcium intake (compared to baseline) by increasing their daily dietary calcium intake. Diet is advocated by the National Osteoporosis Society as the essential source of calcium intake in maintaining healthy bones.

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1. Consensus Development Conference. Diagnosis, prophylaxis and treatment of osteoporosis. Am J Med 1993; 94 646-650.
2. Torgerson, DJ, Iglesias, CP, Reid, DM: The economics of fracture prevention. In The Effective Management of Osteoporosis 2001; 111-121.
3. Cooper, C: Epidemiology of Osteoporosis, Osteoporosis International, Supplement 2, S2-S8. 1999.
4. Eddy, DM, Johnson, CC, Cummings, SR, Dawson-Hughes, B, Lindsay, R, Melton, LJ, and Slemenda, CW: Osteoporosis: review of the evidence for prevention, diagnosis, treatment, cost-effectiveness analysis. Osteoporosis International 8 (Supplement 4). 1998.
5. Cooper, C, Atkinson, EJ, Jacobsen, SJ, Ofallon, WM, Melton, LJ: Population-based study of survival after osteoporotic fractures. American Journal of Epidemiology 1993; 137: 1001-1005.
6. National Institute for Clinical Excellence. Osteoporosis – secondary prevention (No. 87), Jan 2005.
7. Gray, M, Rajaei-Dehkordi, Z, Ewan, M, Wysocki, R: Investigating the potential contribution of community pharmacists in identifying, understanding and meeting the bone health needs of patients in collaboration with GPs. Int J Pharm Prac 2002: 10 (supplement): R34.
8. Osteoporosis scanning through community pharmacy. Pharm J 268; 419-425.

Meera Sharma BPharm (Hons), MRPharmS, PGDip, is professional services pharmacist at Pharmacy Alliance, the professional services division of UniChem. Chris Martin is a non-executive director, UniChem, and a community pharmacist in Pembrokeshire who took part in Pharmacy Alliance's Bone Health programme in Wales.

Continuing professional development

Reflect

Do you know how osteoporosis is diagnosed? Are you aware of the risk factors for the disease? Would you know enough about the screening procedures and potential treatments to be able to participate in a patient-based bone health programme? Could you give adequate advice to people whose osteoporosis has already been diagnosed – both on the medicines they are taking and lifestyle issues?

Plan

If you read this article you will be able to counsel patients with osteoporosis better. You may be able to set up a screening or monitoring service for this condition.

Act

- Revise the mechanisms involved in maintaining bone density. Read the article 'Calcium supplements: benefits and risks' at www.medscape.com/viewarticle/497826?src=mp and 'Calcium's role' C&D Pharmacy Update, November 20, 2004, p21-23.
- Find out the mode of action of drugs used to treat osteoporosis.
- In your practice workbook list the important lifestyle factors in treating osteoporosis and make sure your medicines counter assistants know these points. Record each time you or your staff provide such advice and follow up patients to see if they have been able to make any changes.
- Over a month, record in your practice workbook all prescriptions for medicines to combat osteoporosis. Which is the most commonly prescribed? Why? Why is calcium combined with vitamin D?

Evaluate

The next time you dispense a repeat prescription for a bisphosphonate, ask the patient to tell you how they take the medicine. If they do not know how and why, was it because the original instruction was poorly presented? Try to work out their problem and use this to improve your practice. Do you think you have decreased patients' risk of osteoporosis by using the list of lifestyle changes you have made? Is there any more you could do?

Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the June 3 issue, which will cover this week's CPP-accredited module, together with those in the May 6 and 13 issues.

These will cover:
Adherence part 2 (1368)
Amorolfine for nail infections (1369)
Osteoporosis (1370)
A telephone marking service offers independent verification of results – details on the monthly MCQ papers. People wanting to register for Pharmacy Update can contact Pauline Sanderson on 01732 377269.

Chemist + Druggist
in association with
Genus Pharmaceuticals

C+D

GENUS PHARMACEUTICALS

Clinical news

Limits lifted on skin drugs

Roaccutane (isotretinoin) and Neotigason (acitrecin) are now freely available for ordering by community pharmacies.

Previously, the potent skin drugs could only be dispensed by hospital pharmacies or by community pharmacies that had been specifically nominated by a consultant dermatologist. However, the lifting of this restriction does not alter the monitoring requirements or prescribing arrangements for the two drugs, which should only be by, or under the supervision, of an experienced specialist in the field.

For more information:
www.rocheuk.com or www.medicines.org.uk
Tel: 0800 3281629.

In brief

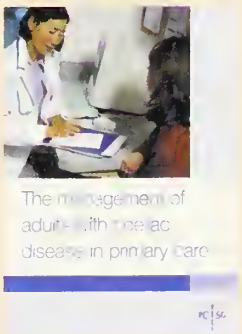
DuoTrav

Alcon has introduced DuoTrav, a combination product for open-angle glaucoma and ocular hypertension. Containing travoprost 40mcg and timolol maleate 5mg per ml, the eye drops are indicated for patients who require intraocular pressure lowering and have not responded adequately to topical beta-blockers or prostaglandin analogues. Recommended dosing is one drop into the affected eye(s) once daily. Price, pack size and pip code information: 2.5ml £13.20 322-1918, 3 x 2.5ml £37.62 322-1926
Alcon Laboratories (UK) Ltd, tel: 01442 341234

Generic sumatriptan

Almus Pharmaceuticals is just one of the companies to launch a generic version of sumatriptan, following the patent expiry of GSK's Imigran tablets. Other companies that have added sumatriptan 50mg and 100mg tablets to their generic portfolios include Teva, Consilient, Hillcross, Ivax, Sandoz, Winthrop, Niche, Arrow, Generics UK, Relonchem and Dexcel. See Pricelist supplement for more details.

Coeliac guidance



New guidelines for managing patients with coeliac disease have been published by the Primary Care Society for Gastroenterology. The document outlines the symptoms, diagnosis and management of the disease, and includes the minimum monthly prescription product requirements for patients. Launched to coincide with Coeliac Disease Awareness Week (May 15 to 21), copies can be obtained free of charge by telephoning 020 8398 8551 or emailing hilary@franklincoms.co.uk

A practical approach...

Pharmacist David Spencer is called out from the dispensary to talk to Narinder Singh, a long-standing patient and customer. He has with him another man David has not seen before, but who is looking breathless and distressed.

"Mr Spencer," says Narinder, "I do hope you can help us, it's an emergency."

"Certainly, if I can," replies David. "What's the problem?"

"This is my cousin, Mandip," says Narinder. "He has come over from India to stay with us for a couple of weeks. He gets occasional attacks of asthma but he always carries an inhaler with him. Maybe it's the change of climate or something, but he arrived yesterday and this morning he started to get a bit wheezy. The problem is that when he went to use his inhaler he found it had jammed and wouldn't work, and I think the anxiety over it is making him worse. I've tried to contact my GP's surgery, but it has just closed until 4 o'clock this afternoon. Could you give him another inhaler, we don't mind paying?"

"Can I see it?" asks David. He looks at the inhaler; it is called Asthalin and it is definitely not working.

Questions

1. Where can David find out what Asthalin inhaler contains?
2. Assuming that David believes this is a true emergency, and that there is a UK equivalent of Asthalin but that it is a POM, can David supply it to Mandip?
3. If he does supply it, what authority for doing so could David cite if challenged?

We will publish the answers next week.

CPD This article can help in the following CPD competencies: G1g, G1h, G1a, C1f. See www.tinyurl.com/194zu

USA gets new quit product

Varenicline, the first smoking cessation treatment that targets the neurobiological mechanism of nicotine dependence, has been approved for use in the USA.

Chantix is a partial nicotinic acetylcholine agonist that has been designed to counter both craving and withdrawal symptoms, and reduces the pleasure experienced when a cigarette is smoked. In development since 1993, the drug is the first quit product to be approved by the US Food & Drug Administration for nearly a decade.

The FDA's decision to fast-track Pfizer's new drug application now seems logical, particularly in light of a paper published in May's International Journal of Clinical Practice. This review of the trial data for varenicline stated that the drug produced significantly higher abstinence rates than bupropion, and had a good side effect profile.

Pfizer submitted a European marketing authorisation application for varenicline for smoking cessation last November.

For more information:
Int J Clin Pract, May 2006; 60 (5): 571-576
www.pfizer.com

Adartrel

GlaxoSmithKline has gained approval for its restless legs syndrome drug Adartrel (ropinirole). Available in three strengths – 0.25mg, 0.5mg and 2mg – Adartrel has been licensed for the symptomatic treatment of moderate to severe idiopathic RLS.

According to the SPC, patients should be started on 0.25mg once daily for two days, then the dose increased to 0.5mg once daily. After one week, the daily dose should be upped until optimal therapeutic response is achieved, usually at 2mg once daily, though a maximum of 4mg may be used.

Patients should be evaluated after three months' treatment. The drug is not recommended for children below 18 years of age, or for secondary RLS caused by renal failure, iron deficiency anaemia or pregnancy. Price, pack size and pip code information: 0.25mg 12s 310-6432 £3.94, 0.5mg 28s 310-6457 £15.75, 84s 310-6465 £47.26, 2mg 28s 310-6473 £31.51, 84s 310-6481 £94.53. GlaxoSmithKline UK Ltd, tel: 020 8990 9000

Google Health

A healthcare search engine is the latest offering from Google. Called Google Health, at www.tinyurl.com/jwtmw, the facility allows users to search for a particular condition, symptom or keyword, and refine the results by treatment, research papers, symptoms, news or alternative therapies.

In brief

Ebixa and INR

Patients taking memantine and oral anticoagulants should be closely monitored, Ebixa maker Lundbeck has warned.

The SPCs for Ebixa tablets and drops have been updated to warn that INR increases have been reported in patients also on warfarin. Although no causal relationship has been established, close monitoring of prothrombin time or INR is advisable in such patients, states the SPC.

For more information, contact Lundbeck medical information on 01908 638972.

WHO reviews Nice

The World Health Organization is to review the National Institute for Health and Clinical Excellence's clinical guidelines programme.

The work has been requested by Nice, and will see a panel of five independent experts assessing the methodology the Institute uses when developing guidance. WHO is hoping to publish its report later this summer.

Nice clinical practice centre director Mercia Page said: "I am sure they will provide a fair assessment of our work and provide valuable feedback that will be used to further improve the quality of our product."

A practical approach... last week's answers

1. The features of scabies include a red, papular rash that starts on the fingerwebs and spreads to the wrists, armpits, genitalia, buttocks and abdomen, but not usually the face. Greyish "pencil-line" burrows may be visible. In eczema, the rash is dry, scaly and often erythematous, typically distributed in the elbow and knee creases, on the cheeks, forehead and outer limbs. Both are intensely itchy and scratching may lead to excoriation and secondary infection.
2. Salma has supplied 1 per cent cream rinse, which is a headlice treatment, not the 5 per cent dermal cream, which is effective for scabies.
3. Scabies may be asymptomatic for several weeks and unknowingly transmitted. Comparatively, headlice is visually detectable soon after infection occurs, and unnecessary treatment is thought to encourage resistance.

cut down with nicorette® nicotine then stop

a new option for smokers who have relapsed

Offering smokers who have relapsed after No Smoking Day another way

Around 1.4 million people made an attempt to stop smoking this No Smoking Day. Whilst many will stay stopped for good, stopping smoking is very difficult and up to 79% may have relapsed by mid-April.[1]

Until recently this presented a huge challenge for the healthcare professional who had limited options to offer the relapsed patient. However, the new cut down with Nicorette then stop strategy is perfectly suited to those smokers who are not ready or able to make an abrupt attempt to cut out all cigarettes.

Prevalence target challenge

Given that no other single avoidable cause of disease accounts for such a high proportion of deaths or hospital admissions as smoking,[2] the National Institute for Health and Clinical Excellence (NICE) called for new strategies to help more people stop,[3] and the Department of Health has set a target to reduce adult smoking prevalence rates to 21% or less by 2010.[4] However, without novel initiatives in smoking cessation, prevalence is currently declining by only 0.4% per year.[5] Experts are in agreement that it is crucial to now help greater numbers of smokers attempt to give up, and to do so more frequently.

Helping many more smokers with cut down with Nicorette then stop

Overall, fifty to seventy per cent of the UK's twelve million smokers are unhappy with their smoking,[6,7] but only 26% of these feel ready to abruptly cut out all cigarettes,[6] meaning that previously, a large proportion of smokers could not be helped. It is estimated that over four million additional smokers could now be helped through the use of cut down with Nicorette then stop.[6]

More than four million additional smokers could be helped by cut down with Nicorette then stop

Efficacy and safety of cut down with Nicorette then stop

Using Nicorette Gum or Inhalator has been clinically proven to significantly increase the chance of successful reduction and ultimate cessation, compared to placebo or willpower alone. Trials were conducted in smokers who were not willing or able to stop smoking. The significant finding of the trials was that one in three smokers who successfully reduced smoking by 50% with Nicorette went on to stop completely within 12 months.[8] In addition, it was found that through using this cut down then stop approach, intention to give up was actually improved in 55%-80% of this previously unmotivated group.[9]

The safety of Nicorette use alongside cigarette smoking was assessed in the cut down with Nicorette then stop clinical trials programme, which found that Nicorette Gum or Inhalator in combination with tobacco is well tolerated and has a good safety profile.[10-14]

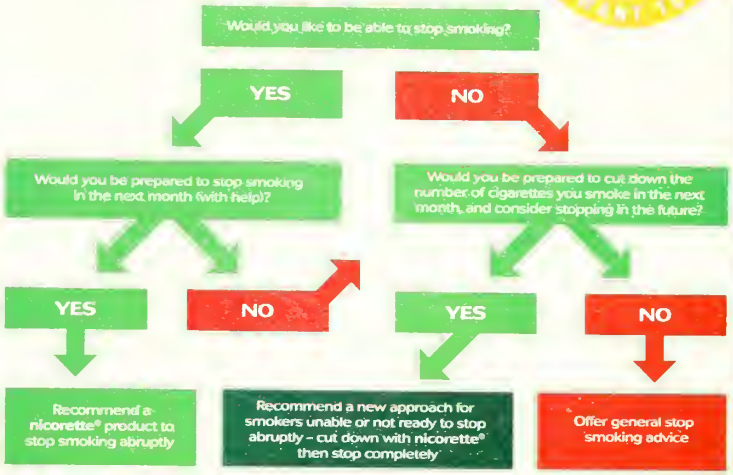
Only Nicorette Gum and Nicorette Inhalator are licensed for this new indication - cut down with Nicorette then stop - providing flexible dosing formats and rapid craving control.

Measure of success

In terms of quit rate success measures, as with an abrupt cessation attempt, the four weeks commences on the quit day which, in the case of those using cut down with Nicorette then stop, takes place after successful reduction of cigarettes for around six months. The clinical trials programme showed that one in three smokers who successfully cut down by half with Nicorette had stopped smoking within one year.[8]

Practical implementation of cut down with Nicorette then stop

Pharmacists are in a key position to provide individual advice and support to help smokers stop, and identifying appropriate smokers for the cut down with Nicorette then stop strategy. With the new Pharmacy Contract stating smoking as a public health priority for those in the field,[4] recent White Papers placing a comprehensive focus on priority issues such as smoking and citing pharmacists as



an integral part of local smoking cessation services,[15,16] as well as NRT being the pharmacological treatment of choice, cut down with Nicorette then stop allows pharmacists to offer an option to those for whom there was previously no help available. A series of simple questions will identify patients suitable for cut down with Nicorette then stop:

Cut down with Nicorette then stop is a four-step process:

Step 1: (0-6 weeks)
Start cutting down
- Smoker sets target for both the number of cigarettes per day to cut down and a date to achieve it by. (Recommend at least a 50% reduction for best results)
- Advise smoker to use nicorette® as required to manage cravings

Advise smoker to return if not cut down within 6 weeks

Unhappy with smoking, not ready to stop abruptly

Step 2: (6 weeks up to 6 months)
Continue cutting down
- Smoker continues to cut down cigarettes using nicorette®
- Goal should be complete stop by 6 months

Advise smoker to return if not managed to stop smoking within 9 months

Increased confidence and motivation

Step 3: (within 9 months)
Stop smoking
- Smoker stops all cigarettes and continues to use nicorette® to relieve cravings

Ready to stop

Step 4: (within 12 months)
Stop nicorette®
- Use of nicorette® is gradually cut down, then stopped completely (within 3 months of stopping smoking)

Ben Youdan, Chief Executive of No Smoking Day welcomes this new option, 'Stopping smoking is incredibly difficult. Millions give it a go on No Smoking Day every year and it's good to be able to offer smokers who have relapsed or feel they can't give up all their cigarettes at once another way of stopping smoking. Cut down then stop offers another route to the ultimate goal of cessation.'

Nicorette Gum Prescribing Information: Presentation: Nicorette 4mg gum and Nicorette 2mg gum contain 4mg and 2mg of nicotine respectively in a chewing gum base. Original, Mint and Freshmint flavours. **Uses:** Relief of nicotine withdrawal symptoms as an aid to smoking cessation. It is used to help smokers ready to stop smoking immediately and also to help smokers who need to cut down their cigarette use before stopping. **Dosage: Adults (over 18 years):** Smoking cessation: After 3 months ad libitum dosage, Nicorette gum should be gradually withdrawn. Smoking reduction: Use the gum between smoking episodes to reduce smoking. A quit attempt should be made as soon as the smoker feels ready. Professional advice should be sought if no reduction in 6 weeks or no quit attempt in 9 months. Each piece should be chewed slowly for 30 minutes. No more than 15 pieces of gum should be used each day. **Adolescents (12 to 18 years):** Smoking cessation: After 8 weeks ad libitum dosage, reduce gum use over 4 weeks. If not stopped by 12 weeks, a healthcare professional should be consulted. Smoking reduction: Only after consulting a healthcare professional. **Under 12 years:** Not recommended. **Contraindications:** Hypersensitivity. **Precautions:** Denture wearers, GI disease, unstable cardiovascular disease, diabetes mellitus, uncontrolled hyperthyroidism, phaeochromocytoma, renal or hepatic impairment. Stopping smoking may alter the metabolism of certain drugs. Keep out of reach and sight of children and dispose of with care. **Pregnancy & lactation:** Only after consulting a healthcare professional. **Side effects:** Headache, sore mouth or throat, jaw-muscle ache, GI discomfort, hiccups, nausea, vomiting, dizziness, erythema, urticaria, palpitations, allergic reactions, reversible atrial fibrillation. See SPC for further details. **RRP (ex VAT):** 2mg gum (30) £3.25, (105) £8.89; 4mg gum (30) £3.99, (105) £10.83 **Legal category:** GSL. **PL numbers:** 00032/0248, 0249, 0250, 0251, 0283, 0295 **PL holder:** Pharmacia Limited, Ramsgate Rd, Sandwich, Kent. CT13 9NJ. **Date of preparation:** March 2006. **Nicorette Inhalator Prescribing Information: Presentation:** Inhalation cartridge containing 10mg nicotine for oromucosal use via a mouthpiece. **Uses:** Relief of nicotine withdrawal symptoms as an aid to smoking cessation. It is used to help smokers ready to stop smoking immediately and also to help smokers who need to cut down their cigarette use before stopping. **Dosage: Adults (over 18 years):** Smoking cessation: 6-12 cartridges per day for 8 weeks. Halve the number of cartridges in weeks 9 and 10. Reduce to zero by end of week 12. Smoking reduction: Use between smoking episodes to reduce smoking. A quit attempt should be made as soon as the smoker feels ready. Professional advice should be sought if no reduction in 6 weeks or no quit attempt in 9 months. **Adolescents (12 to 18 years):** Smoking cessation: As adult dosage, but duration of treatment should not exceed 12 weeks without consulting a healthcare professional Smoking reduction: Only after consulting a healthcare professional. **Under 12 years:** Not recommended. **Contraindications:** Hypersensitivity. **Precautions:** Unstable cardiovascular disease, diabetes mellitus, uncontrolled hyperthyroidism, phaeochromocytoma, hepatic or renal disease, chronic throat disease or bronchospastic disease. Stopping smoking may alter the metabolism of certain drugs. Best used at room temperature. Keep out of reach and sight of children and dispose of with care. Pregnancy & lactation: Only after consulting a healthcare professional. **Side effects:** Cough irritation of throat and mouth, headache, nasal congestion, nausea, vomiting, hiccups, palpitations, GI discomfort, dizziness, reversible atrial fibrillation. See SPC for further details. **RRP (ex VAT):** 6-Starter pack £3.39, 42-Refill pack £11.37. **Legal category:** P **PL holder:** Pharmacia Limited, Ramsgate Road, Sandwich, Kent. CT13 9NJ. **PL number:** 00032/0280. **Date of preparation:** March 2006.

Information about adverse event reporting can be found at www.yellowcard.gov.uk
Adverse events should also be reported to Pfizer Consumer Healthcare Tel: 01304 61 61 61

References 1. Owen L, Youdan B. 22 years on: the impact and relevance of the UK No Smoking Day [illegible] 15; 19-25. **2.** Nicotine Addiction in Britain: A Report of the Tobacco Advisory Group of the Royal College [illegible] **3.** NICE Appraisal Guide No. 38. **4.** Choosing Health Through Pharmacy: **5.** Jarvis MJ. Monitoring [illegible] in Britain in a timely fashion. Addiction. 2003 Nov; 98 (11):1569-74. 6. Data on file IPSOS - [illegible] 24 http://www.ash.org.uk. **8.** Data on file – COTS 001. 9. Data on file – COTS 005. 10. [illegible] with oral nicotine inhalers; double-blind randomised clinical trial of efficacy and [illegible] S et al: Poster presented at the ESRNT, Paris, September 200[illegible] 12. Ra[illegible] Final results from a placebo-controlled trial over 13M. Clinical Pharm[illegible] P, et al. Smoking reduction promotes smoking cessation: [illegible] nicotine gum with 2-year follow-up. Addiction. 200[illegible] Department of Health White Paper on Tobacco. [illegible] Health White Paper, 2004 http://www.dh.gov.uk/Pol[illegible]

Date of Preparation: April 2006

Curanail switches on to nail infections

Curanail (5 per cent amorolfine) has been launched by Galderma following the POM to P switch of the active ingredient.

The once weekly treatment is indicated for mild fungal infections (onychomycoses) and should be merchandised alongside the athlete's foot category.

The nail lacquer provides enhanced nail penetration, remaining active for one week. Treatment takes around six months for infected fingernails and nine months for toenails. Packs include files and applicators.

Galderma is targeting the 25 to 54 year old age group – time poor and unlikely to consult a doctor about the problem – with marketing support to the tune of £1 million. A month-long ad campaign breaks in the national press on June 10 followed by four weeks of TV ads from late June on GMTV, E4 and UK TV Gold.

The adverts will raise awareness of the condition and explain that it is not simply a cosmetic problem. A website offers aids to compliance.

For the trade, Galderma is providing training for pharmacists and their staff, a CD-Rom and point of sale materials.

Price: £18.61/3ml
Galderma
Tel: 01923 291033
www.curanail.co.uk

Adorn gets a respray

Adorn Hairspray has been given a new design and bigger pack size to boost brand awareness and presence on shelf.

Launched in the 1970s, the brand has a loyal usership, claims Keyline.

Cans now contain 250ml, 50ml more than previously. Three variants are available: natural, firm and ultra hold, all subtly fragranced and easy to brush out.

Keyline Brands
Tel: 0208 893 5333
Email: sales@keyline-brands.co.uk

Glucose monitoring advance

The One Touch Ultra2 blood glucose monitoring system will be available next month from LifeScan.

Developed after consultation with diabetes patients and healthcare professionals, the system's features include a large display with backlight and easy to use scrolling buttons, says the company. Results are produced in five seconds from a tiny blood sample which can be taken from the fingertip or arm, adds LifeScan.

The Ultra2 has a 500 test memory and records the time and date automatically.

A freephone customer care line (tel: 0800 169 1622) supports the product. Lancets and strips are available on prescription.

Price: £12.99
LifeScan
Tel: 01494 658750

Senna on a budget

Valupak Senna (7.5mg) has been launched by BR Pharmaceuticals.

Indicated for the relief of constipation, the product "provides a clear alternative to higher priced brands," says the company.

Price: £1.29/20
BR Pharmaceuticals
Tel: 0845 230 1499

VMS report

The UK VMS sector is starting to rally, shows the latest Market and Business Development (MBD) report. After declining by 9 per cent between 2001 and 2004, 1 per cent growth was recorded in 2005, bringing the market value to £343.5 million.

MBD attributes the decline to the loss of retail price maintenance in 2001. This caused a flurry of own-label product launches, resulting in greater volume sales but lower value for the sector.

Over the next five years, the VMS market will increase by 2 per cent in real terms, predicts MBD. Grocery multiples will continue to hold down prices but the aging population and consumers' increasing health awareness are expected to buoy the market.

Demand for multivitamins and minerals is expected to grow at the expense of single vitamins and minerals. Other products such as garlic, ginseng and tonics will show further growth while decline is anticipated for evening primrose, starflower and St John's Wort.

www.mbdltd.co.uk

Products in brief

Hot lips

Color Fever Lipstick has been launched by Lancôme. Available in 32 shades with four effects, the lipstick's pack features metal faces with the Lancôme Rose hallmarked on the top.
Price: £15.50
Lancôme
Tel: 020 8762 4040

Sea spray for babies

Ocean Pure is a new cleansing spray for babies and toddlers. Containing only seawater, the sterile spray can be used for nappy changes and for cleaning hands and faces, says the manufacturer. It is sprayed on and wiped off with cotton wool or tissue. The spray works at all angles and the product's packaging is fully recyclable.
Price: £5.99/100ml
Ocean Pure
Tel: 01730 261089
www.oceanpure.co.uk
Email: info@oceanpure.co.uk

VERRUCA?

national TV campaign

FREEZE IT

with NEW Scholl Freeze Verruca & Wart Remover

There's no more effective way to remove verrucas and warts

- Quick
- Clinically
- Suitable
- Can remove

Scholl

Yeast Vite's wake-up call

Yeast Vite's new look is being promoted with PR and online activity with the strapline 'Yeast Vite for when you need to wake up'.

Trade advertising runs until June designed around the concept of what people do when they are tired. A trade mailer with a competition is also going out in the next couple of weeks.

Sporting orange and blue livery, the pick-me-up product is to get its own website this summer, where surfers will be able to pick up tips on beating tiredness, enter competitions and tell their own tales of humorous mistakes made when overtired.

Product info:
Thornton and Ross
Tel: 01484 848200
www.yeastvite.com

Breathable supports from 3M

A range of supports has been launched by 3M under the Nexcare brand.

The products are made of blue Breathe-O-Prene fabric which moves moisture away from the skin, making the supports suitable for use during exercise, says the company.

Variants for knees, ankles, elbows and wrists are available alongside a maternity support and athletic wrap.

Product info:
Price: £4.49-£19.99
3M, tel: 08705 360036
www.3M.com

Discover Vielle

The Vielle female sexual wellbeing range has been extended with the launch of the Discovery Pack.

Containing a clitoral stimulator and 5ml single use pack of lubricant, the pack will encourage trial, believes DDD.

The stimulator is licensed by the Medical Devices Agency as a class one medical device. It makes orgasm more intense and easier to reach, says the company. It is also available in a three-pack version. The lubricant is suitable for use with condoms and may also be purchased separately in a 50ml bottle.

Product info:
Price: £3.99

DDD Ltd
Tel: 01923 208136
www.vielle.co.uk

Revised instructions

Usage instructions for Colief infant drops have been amended following advice issued by the Department of Health late last year on the preparation of infant formula.

When making up formula, four drops of Colief should be added to warm milk. The milk should be fed to the baby after half an hour. If making up feed in advance, two drops should be added to the milk when warm and refrigerated for four hours. The milk should be warmed before feeding.

Colief is a heat sensitive enzyme and works best in warm milk, says Britannia.

Britannia Health Products
Tel: 01737 773741

Head start for 4head

Magazine and TV advertising for 4head (levomenthol) is beginning this month.

The ads feature clinical trial data confirming the product's speed of action and explain how it works to counter tension headaches.

Product info:
Dendron Ltd
Tel: 01923 229251
www.4headaches.co.uk

Label change for suncare?

Next summer could see the introduction of new labelling on sun protection products. The European Commission wants to give consumers a better indication of the level of protection provided. Current SPFs only relate to UVB protection; the EU believes there should be a uniform system for UVA too. Consumers need more information on how to apply suncare products. The EU wants to see an end to the use of phrases such as 'sun blocker' and 'total protection' because no product can give complete protection against UV radiation.

Gillette kicks off young player award

Gillette is sponsoring a young player award at next month's football world cup.

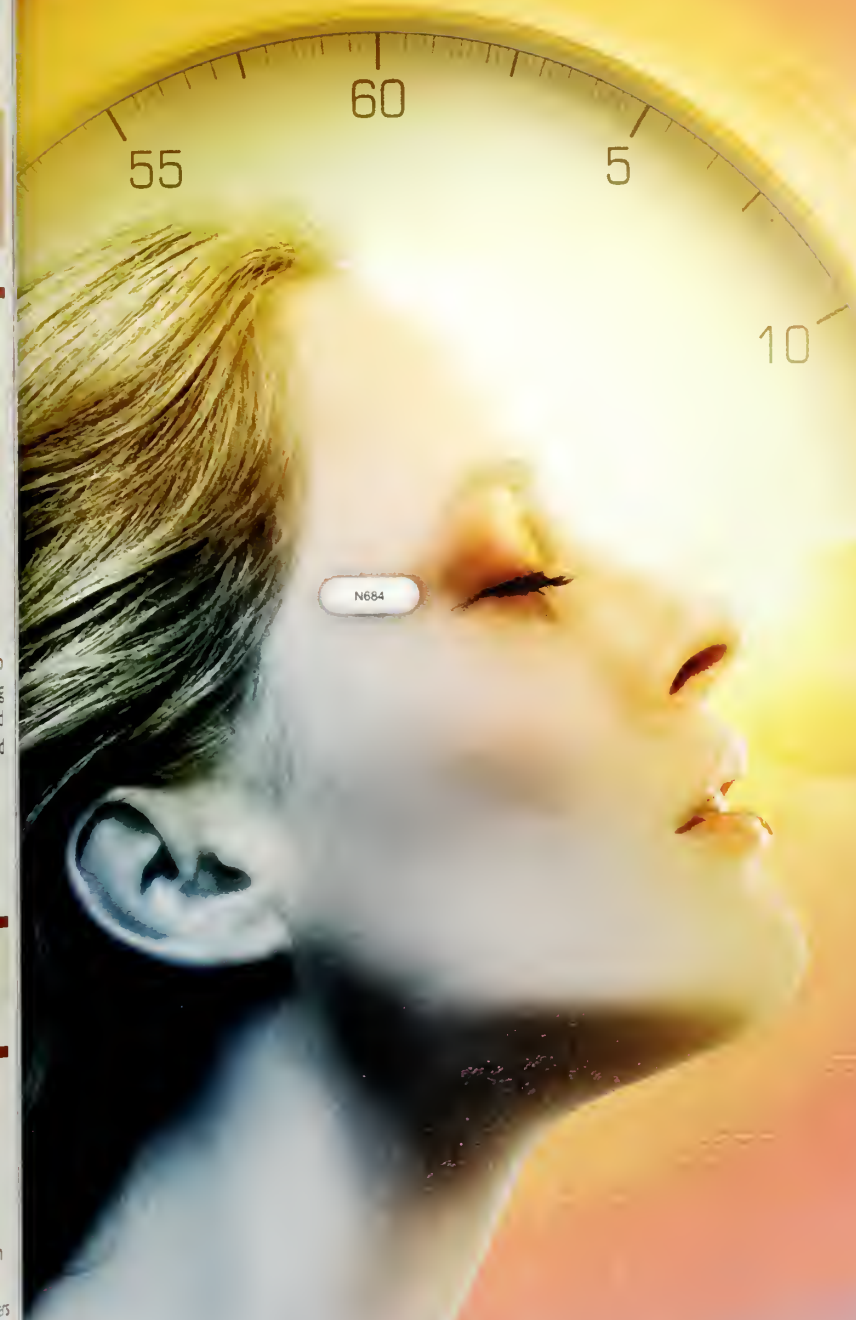
The new honour for players aged 21 or younger will allow fans to vote online. Fifa officials will select the winner from those shortlisted.

Gillette Best Young Player mini-DVDs are being distributed in promotional packs of M3Power and M3Power Nitro razors. Supporting ads are running in 'FHM' and 'Zoo' magazines and on their websites.

Product info:
Gillette
Tel: 020 8560 1234
www.gillette.com/fifaworldcup

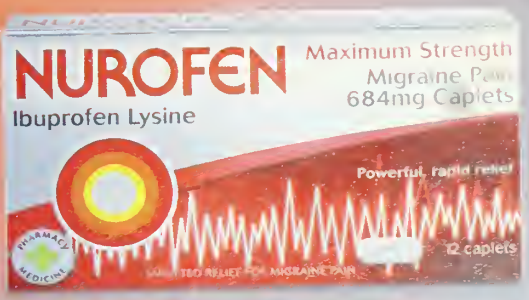
NEW PHARMACY ONLY LAUNCH FROM NUROFEN

Designed for early relief of migraine



Nurofen Maximum Strength Migraine Pain 684mg Caplets have been specially designed for rapid absorption and targeted migraine relief:

- Is a first-line treatment, according to NHS migraine protocol[1]
- Can be absorbed over twice as fast as standard ibuprofen[2] – it is important that treatment works as soon as possible before gastric stasis sets in[3]
- Can also help relieve migraine pain associated nausea[4]
- Does not contain codeine, as required by NHS guidelines[1]



The right medicine for the right patient

Nurofen Maximum Strength Migraine Pain 684mg Caplets. Nurofen Migraine Pain 684mg Caplets contain ibuprofen lysine (684mg ibuprofen lysine). For the treatment of migraine. Dosage: Adults, elderly and children over 12 years: 1 caplet taken with water. Repeat dose if necessary. Do not exceed 3 caplets in 24 hours. Not for use in children under 12 years. Not for more than 5 days without medical advice. Contraindications: Hypersensitivity to ibuprofen or other non-steroidal anti-inflammatory drugs (NSAIDs), asthma, rhinitis, urticaria, history of, or existing gastrointestinal bleeding, Severe hepatic failure, severe renal failure or severe heart failure. Do not use with other NSAIDs, including COX-2 specific inhibitors. In last trimester of pregnancy there is risk of premature closure of the foetal ductus arteriosus. Onset of labour may be delayed and the duration increased with increased bleeding tendency in both mother and child. Precautions and warnings: Caution in patients with certain conditions, which may be made worse. These include: systemic lupus erythematosus and mixed connective tissue disease, gastrointestinal disorders and chronic inflammatory intestinal disease, hypertension and/or cardiac impairment, renal impairment, hepatic dysfunction. Bronchospasm may be precipitated in patients with bronchial asthma or allergic disease. GI bleeding, ulceration or perforation. Caution in patients on medications which increase the risk of gastrotoxicity or haematological toxicity. GI symptoms should be monitored at initiation of treatment. The elderly are at increased risk of consequence of adverse reactions. Fertility may be impaired by a reversible effect on ovulation. Side effects: In short-term use, at OTC doses, side effects are uncommon or rare. They include abdominal pain, dyspepsia and nausea. Hypersensitivity reactions are uncommon, and may include non-specific allergic reactions, anaphylaxis, respiratory tract reactions (asthma, bronchospasm) and various skin reactions (pruritus, urticaria, angioedema). For a full list of side effects, see the Summary of Product Characteristics. MRRP: £4.49 12 caplets. Legal category: P. Product licence Number: PL 00327/0. Manufactured by Crookes Healthcare Limited. Date of Prescribing Information: [illegible]

Clarification

The new Blister Plasters and Soft Gel Toe Support are available from Profoot, not as stated in C+D, May 13, p28.

Product info:
Miles Group Ltd
Tel: 01484 536344
www.profoot.co.uk

Gradual approach to quitting

According to Nicorette, 1.4 million people gave up smoking on No Smoking Day.

However, data collected in previous years suggests almost 79 per cent of quitters relapsed within a month of the event. Often six or seven attempts are needed to stop completely.

For those finding it difficult to stop abruptly, Pfizer suggests cutting down gradually using Nicorette Gum.

Pfizer
Tel: 01304 616161
www.nicorette.co.uk

Products advertised on TV next week

Aquaban: GMTV, five, Sat
Aquaban Herbal: GMTV, five, Sat
Aquafresh: All areas except U, CTV, GMTV, Sat
Buscopan: C4, GMTV, Sat
Dulcolax: GMTV
Hedrin: GMTV, Sat
Lamisil Once: All areas except GMTV
Listerine Advanced Tartar Control Mouthwash: All areas except Sat
Lucozade Sport: All areas except U, CTV, GMTV, Sat
Natravene: All areas except C4
Optrex Dry Eyes: All areas
Optrex Lubricating Liquid Gel: All areas
Piriton: All areas except U, CTV, Sat
Rennie: All areas except CTV
Ribena: All areas except U, CTV, GMTV, Sat
Sensodyne: All areas except U, CTV, GMTV, Sat
TCP Spray Plaster: All areas
Wartner Wart & Verruca Remover: G, Y, C, M, CAR, Sat
PharmaSite for next week:
SSL Full Marks – Windows, **SSL Full Marks** – In-store, **Allergan Refresh** – Dispensary
Pharmacy channel:
Scholl Freeze, Pfizer Regaine

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

Camera shy

Digital technology has demoted film as the favoured photographic medium. What can pharmacies do to profit from the process?

Max Gosney

Pharmacy and photography go way back. Since William Fox Talbot first patented his process of fixing prints on light-sensitive paper in 1841 the pharmacy has become a reference point for picture processing. But the rise of digital has fast-tracked 35mm film towards the same fate as vinyl and VCR and challenged the future of pharmacy's ties with photography.

Digital camera sales topped six million in 2005 compared to an annual 25 per cent drop in film sales, according to Photo Marketing Association International. Nigel McNaught, the organisation's UK director, says: "Wholesalers who've traditionally collected film from pharmacy have cut down their service or stopped completely. If the pharmacist can't get his films picked up he can't afford the service."

But by adapting their service to the switch pharmacists can still prosper in the digital age, advises Mr McNaught. "If the pharmacy wants to retain some photographic business they've got a number of options. There's a range of camera accessories like memory cards. If you want to compete in the area of processing the big decision is whether to go for a kiosk or a mini-lab."

A kiosk costs from around £5,000 and provides an easy-access point for customers to process digital photos, according to manufacturers. Production costs tend to be higher so average final print prices range between 40 and 50p. Mini-labs, by contrast, are much larger and more expensive, but due to their size can produce prints for sale at more competitive prices of around 10p each.

Choosing between the formats depends on the direction of your trade, says Roy Sealey, sales director at photo distributor Swains. "Digital provides a massive opportunity to get into the kiosk business. I'd recommend it over a mini-lab where you have to be doing a lot of prints to justify the cost," he says. Pharmacists can expect to be back in the black around a year after purchase, predicts Mr Sealey. "Pharmacies were the home of film processing and I think things have gone full circle with the arrival of kiosks," he says.

However, not all kiosks will make you a photo king, warns Clive Turner, sales and marketing director at photographic wholesaler Colorama. "Not all kiosks are equal and if you want to compete they must be able to do three things. Firstly, burn images to a CD. Secondly, be able to send images via the internet and finally be able to print hard copies." Failure to comply with the checklist could leave you counting the costs, warns Mr Turner. "The critical thing if you are going to compete with supermarkets is quality and retail price. Price can be kept low through a mini-lab's

> If you want to compete in the area of processing the big decision is whether to go for a kiosk or a mini-lab

Digital has opened up the market to other providers, but with the right offer pharmacy can still play a key part

economy of scale. However, a kiosk can also deliver low cost prints via internet connection to a central lab. A kiosk can do everything a mini-lab can do at a fraction of the purchase price."

Another method could be to mix and match between the techniques, advises Andrea O'Hagan, marketing and communication manager at mini-lab supplier, Photo-Me. "If you are a pharmacist with an internet-linked kiosk then you might look to team up with a mini-lab owner," she says. "Both methods have pros and cons. A mini-lab generates cheap images but they can cost around £50,000. A kiosk is cheaper but people are unlikely to print a large number of images out at 49p each." Kiosks also present customer confidence issues, adds Ms O'Hagan.

"I would say there's a training issue similar to when ATMs first arrived. I've sat in shops where people have been scared about using the kiosk. One in five customers need help and I think there are privacy concerns."

Kiosk designers are responding by tuning the technology to put patients at ease, says Alan Lamport, spokesperson at photographic distribution and marketing firm, the SMI Group. "Most kiosks will talk the customer through the process to simplify things. At the beginning people are hesitant, but they quickly master the challenge." Pharmacists, adds the SMI chief, have the pulling power to ensure that their digital printing service can eclipse competition from internet operators at home printing technology. "The trouble with using an internet operator is you don't know what the quality will be. If you've been using your local pharmacy for years there's a trust and expectation," he says.

Converting that confidence into sales success is where many contractors are falling short, says William Penrice, major accounts manager at photographic equipment manufacturer Noritsu UK.

"I don't think the majority of pharmacists use enough branding to promote photographic products. There's also very little advertising of their services to the general public, which is a real issue." Pharmacies may find it tough to reproduce the success they enjoyed selling film but with a little forethought they can still do very well from digital, concludes Mr Penrice. "Ten years ago pharmacies had a much bigger stake in photography because it was where your mum would go to get the holiday photos done. Digital has opened up the market to other providers, but with the right offer pharmacy can still play a key part."

Heaven sent: Digital technology provides a "massive opportunity" for pharmacy, claim photography experts. Image by Emp

Colorama backs dawn of the kiosk

Touch-screen kiosks could be the best bet for pharmacists looking to capitalise on a digital market, which has doubled since 2003, claims Colorama.

The photographic wholesaler and finisher's dawn units include an optional online shopping service and are supplied in counter top or wall mounted formats. The kiosks, which cost around £5,000 with a printer, also feature CD photo storage and broadband transfer to a central Colorama lab.

Colorama, tel: 0845 270 0470

Longer lasting batteries

Duracell has launched a battery range designed for use in digital cameras.

Duracell powerpix powered cameras will take three times as many photos as those fuelled by standard alkaline batteries, claims Duracell.

The batteries are available in AA and AAA sizes. Duracell recommends the format for customers who use their cameras up to three times a month.

Duracell, tel: 0800 716 434

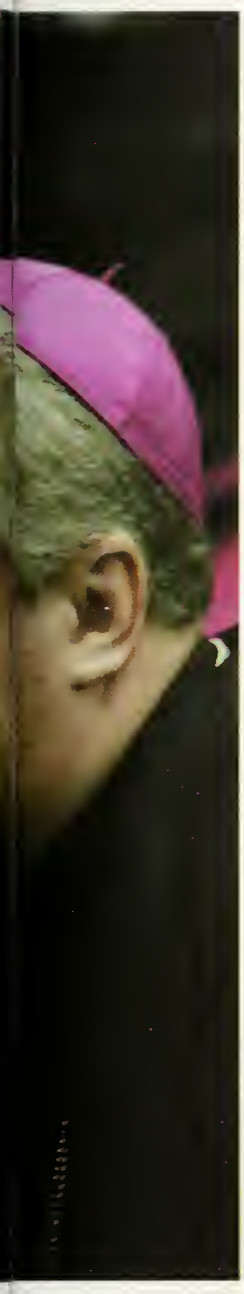
Digeprint printer deal

Digeprint has launched a "high quality" digital print processor for retailers.

The Digeprint DPP305 can service kiosk demand for prints up to 12x18in or function as an overflow for mini-lab systems, claims Digeprint.

The firm's managing director, Trevor Elworthy, comments: "It's a new direction for effecting digital image exposure onto RA4 photographic paper which is far more desirable, both aesthetically and economically, than inkjet media. We have broken new ground."

Digeprint, tel: 02476 323 360



Go for the compact option

A compact mini-lab could drive profits from digital photography at your pharmacy, says the SMI Group.

The MarKo MK4 provides a "revenue generating" mini-lab, which will fit into a 10sq ft floor space, claims the photographic manufacturing and distribution company. The unit can produce up to 400 4x6in prints an hour, according to SMI. Other features include multi-tasking software to allow CD burning, media reading and film scanning while printing and connection to a local area network to receive digital files over the internet, adds SMI.

SMI, tel: 0870 403 6470

Large it up with Fuji Hunt

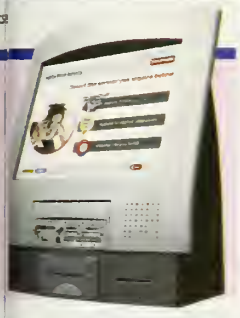
Fuji Hunt's printhunter system could put your pharmacy in profit within four months of purchase, claims the company.

The technology can be combined with a mini-lab system to create a 'color service centre', according to Fuji Hunt.

Installation allows pharmacists to make a 75 to 85 per cent margin on the sale of "large, high quality" photos, says the company. Contractors selling five 'super-enlargements' of 24x30in per day will cover the costs of the kit in under four months, claims Fuji Hunt.

The 'color service centre' including printer and software costs approximately £4,000.

Fuji Hunt: 02476 455 575



Chip and pin kiosk

A TV advertising campaign will celebrate the launch of Kodak's chip and pin kiosk this summer.

The G4 kiosk, which will be supplied by photo distributor Swains, offers payment by credit or debit card to speed up sales, according to Swains. The kiosk provides an ideal opportunity for independent pharmacists to gain a foothold in the digital photography sector, says Roy Sealey, sales director at Swains. "It's a great idea to start with this kiosk and build your business from there."

Swains, tel: 0845 4504242

Grand designs

Associated Chemists Wicker, C+D and Ceuta's Platinum Design Awards winner, is an extraordinary business that has opened every day since 1952

Gary Paragpuri

It's no surprise that Associated Chemists Wicker has become a Sheffield landmark. Having been open every day since 1952, the business has firmly established itself as *the* late night pharmacy in the city.

During its 54-year history the pharmacy has pioneered many health initiatives and currently provides drug treatment services to more than 400 registered patients. The business has also expanded to include the Sheffield Mobility Shop and H+H Systems, with the latter supplying stock organisers for shelves and pharmacy fridges.

But things have not always been so rosy. In 2004 the company was served with a compulsory purchase order on part of its premises to accommodate Sheffield's inner relief road.

But nonetheless, some two years and an investment of about £700,000 later, Associated Chemists Wicker has emerged as a quite extraordinary example of cutting edge pharmacy design. The pharmacy, located in a former Midland Bank building, boasts a robotic dispensing unit extending over two floors to service two dispensaries, a separate reception area for users of the methadone service, plasma screens for delivering health information, and four different types of consultation area.

Shopfitting company Dollar Rae has certainly made the most of the former bank's high ceilings to create a spacious pharmacy. "They certainly produced the wow factor when they presented their ideas to us," says pharmacist and managing director Martin Bennett.

It's hard to disagree. In its brief, the company's management board said it wanted to create a "multi-pharmacist group practice equipped to provide the facilities, technology and support staff necessary to deliver future pharmacy services". And Dollar Rae has duly delivered.

The high ceiling with lights suspended from 'floating canopies' creates an illusion of space and calmness as customers enter through the main entrance (a second discreet doorway leads to the dedicated drug addiction treatment area, left).

There is a purpose-built unit for signing prescriptions complete with a lowered section for wheelchair users. The unit also has a selection of newspapers for customers to browse while waiting.

At the main counter (also with a lowered section), privacy 'fins' at both till and prescription-out points ensure conversations cannot be overheard. A screened area at the end of the counter offers greater privacy.

Elsewhere, the pharmacy, which only sells medicines and medical products, includes a consultation area within the main shop floor and a consultation room accessed via a short corridor.

The consultation area, equipped with seating, a table, computer and sink, is used for one-to-one smoking cessation sessions, EHC supply and for conducting MURs. The design allows the pharmacist to have a clear line of sight into the dispensary and *vice versa*, while still fulfilling privacy requirements. The equally well-equipped consultation room is used for truss fittings and MURs.

A second dispensary, for care home and home delivery prescriptions, is located on the first floor, directly above the one on the ground floor, a set up that allows both to make use of the robot.

The refit has not been confined to the pharmacy, however. Dollar Rae's design also extends to the mobility centre next door. Although the two businesses are currently housed in separate buildings, the plan is to knock through the dividing wall to create a single large floor space encompassing the pharmacy and the mobility centre sales area.

Making the move

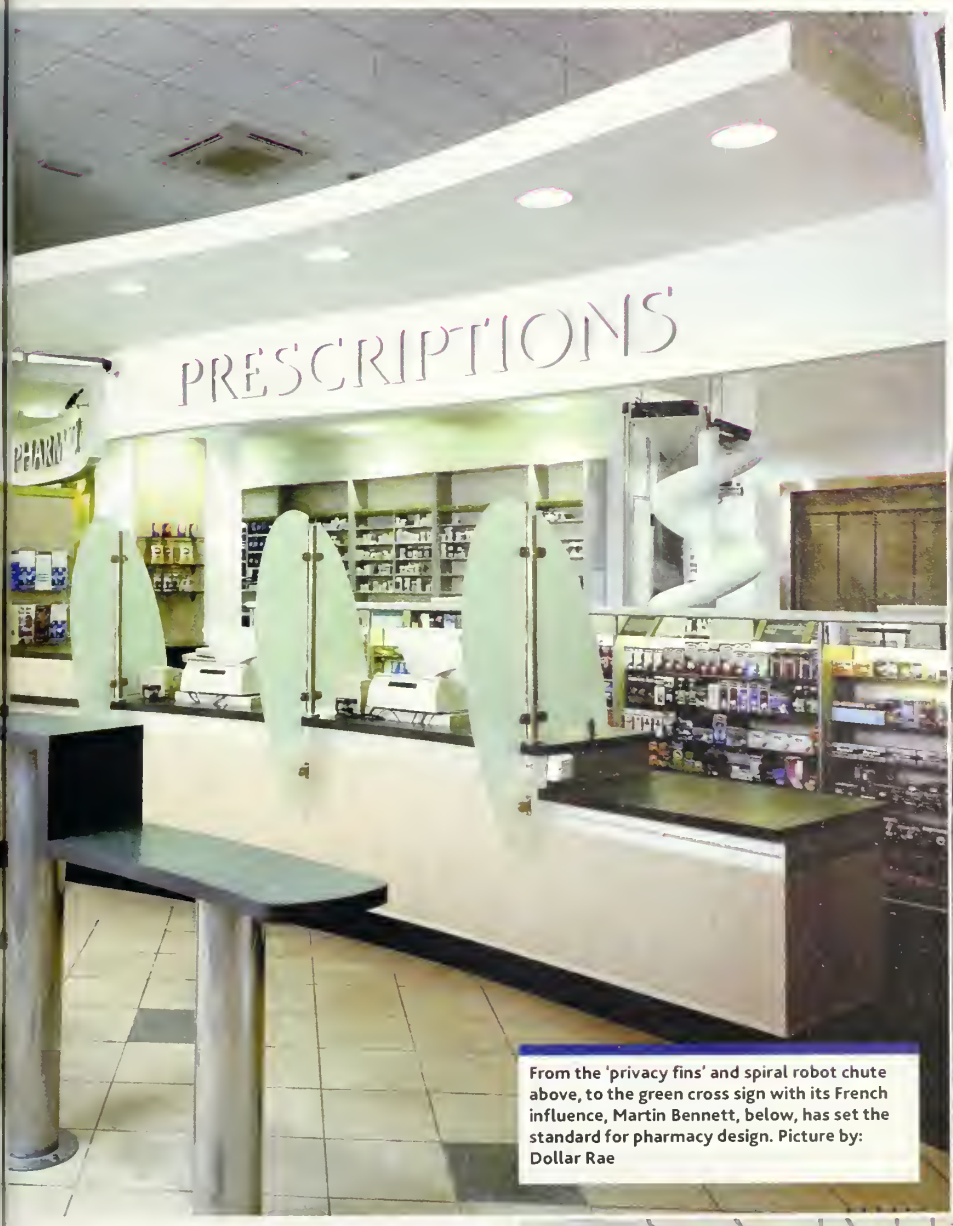
News that a relief road is to be built through your pharmacy is hardly welcome, but for Associated Chemists Wicker it was the perfect opportunity to

The details

Dollar Rae's contemporary design incorporates a host of customised features including a separate entrance to the addiction treatment area and wheelchair access signs.

The design touches

- Floating canopies to support the lighting and maintain the high ceiling.
- Curved dispensary benches to aid workflow.
- Internet linked PC on medicines counter allows staff to search for information that can be printed for customers.
- Plasma screens deliver health promotion to patients, also used to show robot working.
- Four types of consultation area.
- Six IT workstations linked to the Rowa dispensing robot, which serves dispensaries on the ground and first floor.



From the 'privacy fins' and spiral robot chute above, to the green cross sign with its French influence, Martin Bennett, below, has set the standard for pharmacy design. Picture by: Dollar Rae

move into new premises – albeit just next door – and a chance to build an innovative pharmacy.

"When we were first told about the road, we tried to find premises that we could move the whole lot into. But it had to be in the area to retain the contract," says Mr Bennett.

In the end, the solution was on their doorstep, with the empty bank building next door to the existing pharmacy and mobility shops. "I had always thought it would make an excellent pharmacy, albeit slightly different to the average," explains Mr Bennett.

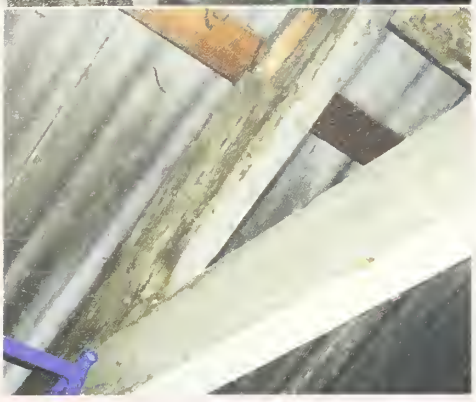
He initially tried to get the GP out of hours co-operative involved in the development but without any luck. One of the drug treatment clinics was also interested but had problems raising funds to develop the premises.

After toying with the idea of moving the mobility centre into the bank, it was decided to shuffle everything along, with the pharmacy moving into the bank, and the mobility shop taking over the space left behind.

The next task was to design the layout. "I had a drawing of the [bank's] space and I sat down and drew roughly the layout I wanted," he says.

The NPA was also asked for input. It made some alterations to his "square drawings" and suggested three companies as suitable bidders for the work but, Mr Bennett, who had been impressed with

The building



Top: The PCT showed a keen interest in the strong room of the former bank and thought it "might be a good place to house their Tamiflu stocks"
Below: Rare Baltic alphabet inscriptions found on beams in the mobility shop

Associated Chemists Wicker history

- Opened in 1952 at 61 The Wicker
- In 1979 it expanded to include numbers 63 and 65
- In 1985, also took over numbers 69 and 71 to accommodate expanding mobility centre
- In 1986, number 67 was added

Our constant is that we are constantly changing. We have been changing the way we do things since we moved in

Dollar Rae's work, also asked them to bid.

A layout prerequisite was that the ceiling height be retained, as it was felt that it could help to alleviate any tension in the drug treatment area. "If you put someone in a very small space, with the ceiling pressing down on them, there's a tendency for them to start getting a bit aggressive, whereas in a big space that's less so," he explains.

"We described that to everyone; some said it would be difficult to heat and light but Dollar Rae came up with the best solution." Its plan for floating 'canopies' to house the lighting while retaining the original ceiling height along with the curved dispensing benches were enough to seal the deal.

Dollar Rae also used frosted glass walls for the separate drug treatment area to maintain the feeling of space by allowing light in, something, Mr Bennett believes, was "very much appreciated by the clientele who were quite surprised when we refitted the drug treatment area to the same standard as everything else".

The finished pharmacy

Associated Chemists Wicker shouldn't really exist. There are no GPs in the immediate area and every patient passes at least one pharmacy to get here. Yet the business dispenses prescriptions from 300 different doctors every month.

Since the refit, prescription figures and consultations have risen significantly. Counter sales have stayed the same, however, partly due to the pharmacy having less retail space and partly due to the restricted access as a result of the relief road construction. Overall, the refit has been well received by staff and customers alike. "It's just easier. The previous premises was on various levels and staff were forever going up and down steps, and the second dispensary was in a back room with no windows," says Mr Bennett.

A survey among the drug treatment users in February last year also generated much positive feedback, with 76 per cent in favour of the separat entrance, and 84 per cent saying there was enough privacy. The move into the bank has also provided much-needed space, and some of the rooms are currently leased to a dental technician and a hearing aid company. Other rooms will be developed as training areas for pharmacy staff and for staff from nursing and residential homes.

Developing the service

Associated Chemists Wicker has long championed the use of second pharmacists. It was the first initiative Mr Bennett introduced after his arrival in 1973.

Since then, the company has expanded to 60 staff, a number of whom are part-time. About 15 are required to cover the two dispensaries. This includes five checking technicians and three pharmacists.

In the upstairs dispensary, nearly all the process is done by technicians, as it's basically all repeat dispensing, says Mr Bennett. "It's all about putting in safe systems to make it work."

Pharmacists too are still needed but more for dealing with queries and talking to patients, he says. He would also like to see pharmacies becom more like walk-in centres and be able to use all th PGDs that walk-in centres use.

Other areas of possible development include having prescribers on site. With the large number of patients registered with the pharmacy's drug addiction service, there is scope for pharmacist prescribers to carry out inductions and manage repeat prescriptions, he thinks.

"Over the years we have been frustrated by knowing what patients need but we haven't been able to give it to them. But I see pharmacists working in more clinical roles and we now have th facilities here for a group practice. Pharmacists wi in the future have their own patients as well as doing their day job."

Associated Chemists Wicker has certainly come a long way since 1951, when 45 Sheffield pharmacists decided to form a company to provid

A separate drug treatment area has been set up for the 400 registered patients. Harm minimisation messages are displayed on the plasma screen, while the 'sunlight on methadone' mural in the background adds to the pharmacy's atmosphere

Timetable for redesign

- **May/June 2004**: buy empty Midland Bank property and arrange planning permission, architect and shopfitter plans
- **June/July**: finalise plans and secure contractor
- **August:** start work on roof, fire escapes, lift, robot and electrics
- **September**: installation of suspended ceiling, air conditioning, windows and signs
- **October**: flooring, computer systems, CCTV and robot put in
- **November 15**: open

Above (top): the needle exchange area, and (below) the staff of the mobility centre

an extended hours pharmacy for the city. Little did they know that the pharmacy they would open in January of the following year would quickly become a model pharmacy to be copied in other towns, such as Stoke, Stockport, Newcastle, Birmingham and Leeds.

In its latest reincarnation, Associated Chemists Wicker has once again become a blueprint for the next generation.

The name

The Wicker, which is known as the place "weer t'watter runs oer t'weir", is a Sheffield landmark. It gets its name from the local basket makers who plied their trade on the banks of the river Don, which flows beneath one end of the Wicker.

Fancy working at a cutting edge pharmacy? See page 45 for more details ›

Different needs, different dressings

In the £60.9 million first aid dressings market, Beiersdorf is constantly looking to develop new products. But while advanced dressings – such as the recently launched Spray Plaster – add value to a relatively static category, it is Elastoplast's core range that many consumers instantly associate with the brand.

Plasters comprise 60 per cent of all category sales. The Elastoplast offering ranges from cushioned for areas when friction may cause discomfort, to sensitive variants for those suffering from allergies. But rising above all are Elastoplast fabric strips. This product has been available in the UK for over 80 years and remains the top selling plaster.

Children are particularly susceptible to cuts and grazes, and with this in mind, Beiersdorf was the first company to introduce a character plaster to the market with the 1989 launch of Mickey Mouse[1] plasters. As well as kids enjoying the novelty of having Winnie the Pooh[2] or Barbie[3] on their knee or finger, parents know that the dressings conform to Elastoplast's usual high standards, yet are formulated with a special kind of adhesive that makes them easier – and less painful – to remove.

Other advanced dressings are designed to meet specific needs:

- **Aqua Protect** – ultra thin, waterproof and breathable, these plasters protect the skin during washing, making them particularly suitable for active people.
- **Faster Healing** – contains a gel that absorbs wound exudate yet maintains a moist environment, accelerating the healing process by 50 per cent and reducing the chance of scarring.
- **Clean & Protect** – a convenient two in one product comprising antiseptic wipes and plasters.
- **Scar Reduction** – patches that flatten, soften and lighten scar tissue to improve appearance in approximately 8 weeks.
- **Burn Relief Spray** – the mousse formula relieves pain, cools the burn and prevents the spread of heat in the skin.
- **Burn Plasters** – the foam pad acts a barrier to prevent moisture loss, help protect the site from knocks, and minimise the risk of infection, promoting rapid healing.

The summer is the perfect time of year for pharmacies to review their first aid offering, as this is when people stock up on products, both to take on holiday and because children are more likely to get injured. Ensure your pharmacy stocks a good range of dressings, and that the shelves are clean and tidy. And don't forget to link sales, by pointing your customers towards antiseptics and other holiday supplies.

References:
1. © Disney
2. © Disney based on the "Winnie the Pooh" works by A.A Milne and E.H Shephard
3. © 1999 Mattel, Inc.

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Nine go running for Coeliac UK

Marathon effort will help improve lives of people with coeliac disease

From the left: Jaclyn Bent, Kim Dugmore, John Fitzpatrick, Andy Chapple, Jane Phelps and Aaron Smith pictured before their marathon run

Nine runners took part in the London Marathon to raise money for Coeliac UK, the charity that works to improve the lives of people living with coeliac disease.

The runners included Andy Chapple, from Chedworth, near Cheltenham, who was diagnosed with coeliac disease nearly nine years ago. He has run four previous marathons, but this was his first since diagnosis. He proved being a coeliac does not stop you doing something physically demanding by clocking up a time of 2hr, 56min, 52sec.

"I wanted to test my abilities now that I have my diet under control," he said. "I needed the challenge and a goal with a training discipline."

From the other end of the country, Jaclyn Bent, a physiotherapist from Hamilton in Scotland, ran her first marathon in 3hr, 58min, 26sec. She discovered that she was a coeliac four and a half years ago. Her brother and sister also have the disease and it is thought that there is a one in 10 risk of having the condition if it exists in the family. "Coeliac UK has provided help, support and advice over the years and I wanted to give something back," she said.

All the runners had a sponsorship target of £1,000 and Glutafin, the producer of gluten-free foods, donated £100 for each runner.

Rowlands raises funds for kids charities

Rowlands is to donate all of the profits raised from sales of Rowland Owl merchandise in its pharmacies to two child protection charities.

The Rowland Owl cuddly toy, story time CD and children's fun packs containing colouring books, crayons and jigsaws will be displayed in Rowlands pharmacies in a special NSPCC and Children 1st branded unit, which highlights that all profits from these items will go to a worthy cause.

The pharmacy chain is encouraging staff to take part by offering prizes to branches that sell the most Rowland merchandise in each area over the next eight months.

Northern pen pal

Kemiston Driggist

The promotional letter from National Pen Ltd in Manchester said this LaserGrip pen is the "perfect business gift for the 21st century".

It is a pity therefore that the company couldn't get the name right. Although the address is completely accurate, the addressee lacks a little something...

To be fair, it is a reasonable phonetic approximation of 'Chemist + Druggist', but the gold lettering has been engraved by laser on the pen, serving as a permanent reminder of how inaccurate computerised mailshots can be.

Of course, we plan all our mistakes.

Pharmacy overcomes theft to support bear campaign

A Preston pharmacy has helped a neighbouring businesswoman raise more than £3,000 for charity.

Tariq Malik, Joan Kershaw and Julie Bibby from Kingsfold Pharmacy in Penwortham joined Janine Jordan and her friend Nazma Ahmed on a 30-mile cycle ride in support of Animals Asia Foundation, a charity that rescues and rehabilitates bears that are kept in tiny cages on farms in China and milked for their bile.

Ms Jordan, director of Care Staff Solutions, a social care recruitment agency next to the pharmacy, said: "I am completely against cruelty and when I saw the horrendous treatment of China's Asiatic moon bears I wanted to do my bit."

She persuaded her colleagues to cycle from Preston to Lytham on Sunday April 30, a round trip that took three hours.

The pharmacy also raised more than £200 for the charity, in spite of the fact that the collection box was stolen when thieves broke into the shop earlier last month.

"They didn't steal anything else," said Mr Malik. "We honoured the money pledged on the sponsor sheet and added to the £50 that was stolen."

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Healthcare professionals recommend salicylic acid

as a first line pharmacy treatment for verrucas and warts![1]

Salicylic acid is a painless and effective treatment for warts and verrucas. It is recommended by healthcare professionals as a first line pharmacy treatment for verrucas and warts[1] – and is the active ingredient in number 1 selling[2] Bazuka Gel. So make Bazuka your first choice recommendation when your customers need to Bazuka that verruca.

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